THE CANADIAN NURSE

L'Infirmière canadienne

VOLUME 53 • NUMBER 12
MONTREAL
DECEMBER 1957

A
Merry Christmas
and
A
Happy New Year

CAROL, GAILY CAROL

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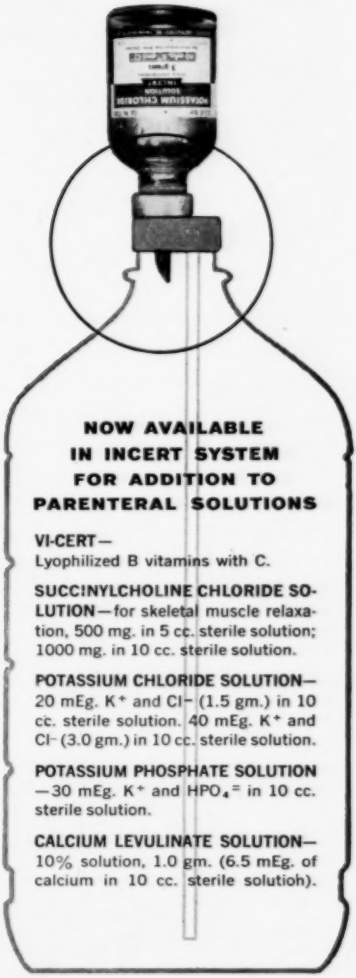

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THE CANADIAN NURSE

L'Infirmière canadienne

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Between Ourselves

CHRISTMAS MEANS MANY THINGS to many people. For most of us it is a time of gladness, of rejoicing, of well-wishing, of gaily trimmed Christmas trees, especially those that are lighted in the front yards.

But Christmas is more than bright lights shining on the snow. It is more than the department store Santa Claus, the bustling shoppers carrying gay packages, the children gazing longingly through shop windows. It is more than Christmas carols on the midnight air, the hustle to get the last cards addressed, the kitchen filled with the good smells of holiday baking.

What, then, is Christmas? To children, it is a *time of excitement and fun.* They want intensely to be a part of its joys and preparation. With all the hurry and bustle before Christmas it may seem that they are always underfoot just when we are busiest. Let them share in the tumult and at the same time keep them happily occupied by showing them how to make Christmas decorations, gift cards, even small gifts. They will have fun designing, cutting, coloring inexpensive little items if you start them off with simple ideas. How about paper strings for the tree? Gay boxes to hold individual portions of nuts or candy? Fudge is fun to make and an exciting decoration for a small Christmas tree on the table. Even decorating the fudge itself is an amusing pastime. Dragees, colored granulated sugar or other cake decorations can be placed on it. Or, tie the squares with gold or silver cord like miniature Christmas packages.

Christmas is the *time of longing.* Continents may separate us from those we love yet miles disappear in a twinkling as long distance telephone calls bring us close together for an instant. The seconds tick past with lightning speed as one after another of the distant family or friends adds another remembered voice to the chorus. "Have a happy time this Christmas!"

Christmas is a *time of loneliness* for many — the young student nurses who are away from home for the first time; the graduate who is working in a strange community; the patients — young and old — who must stay in hospital. While every effort is made by the hospitals to create an atmosphere of happiness for students, staff and patients, those of us who make our homes in the community could do much more than we do. The fun, the intimacy, even the work of preparing the dinner and cleaning up afterwards help to fill the horrible gap of loneliness at Christmas. Let us send our invitations early to nurse-guests so that they will have the pleasure of anticipation and will not come as total strangers to the party. It takes a lot of emotional maturity to get rid of loneliness even in a cheery gathering if she is a last-minute invited guest.

Christmas is a *time for remembering.* We all know the pleasant lift we receive from a chatty note written by an old friend. Perhaps we have felt a slight twinge of regret that we had only signed a name on the cards we sent. "What could I say in just a few lines that would be interesting?" The technique is really very simple. Think of such note-writing as conversation put on paper and it ceases to be a chore. If we close our eyes and imagine we are actually talking with the other person, it is amazing how easily a few interesting newsy items can be dashed off.

Christmas is the *time for giving,* not of elaborate, expensive gifts but of simple, homely things our friendship tied up in bright wrappings. Let us share our friendship generously.

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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. Med. 53:2233, 1953. **2.** Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951. **3.** Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949. **4.** Turell, R.: New York St. J. Med. 50:2282, 1950. **5.** Marks, M. M.: Missouri Med. 52:187, 1955.

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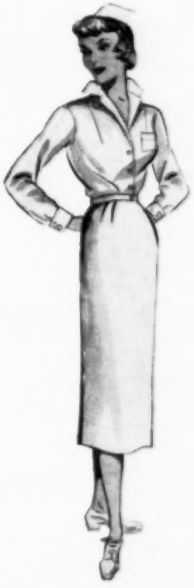

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THE CANADIAN NURSE

L'Infirmière canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 53 NUMBER 12

MONTREAL, DECEMBER, 1957

Bring Back Christ to Christmas

THE "BRING BACK CHRIST to Christmas" campaign, that originated at Mount St. Vincent College, Halifax, in 1950, is a continent-wide, inter-denominational effort to remind people of the true meaning of Christmas. Past generations celebrated this best-loved of all holidays primarily as a religious and family feast day. The fact that Christmas is Christ's birthday was of first importance. From that flowed the gift-giving, visiting and family reunions so dear to all. The twentieth century has witnessed both a regrettable over-commercialization of the great day, and an exclusion of Him whose very name gives us the word Christmas. The widespread use of "Xmas" instead of "Christmas" is considered by many as a startling illustration of this exclusion — a common meaning of "X" being an "unknown quantity."

Many Christians in America, where this state of affairs is much more prevalent than in Europe, were alarmed that Christ *was* becoming an "unknown quantity in Christmas." For the past few years, interested groups from many religious denominations throughout Canada and the United States, have been working together to "de-commercialize and re-Christianize" Christmas. However, it should be noted that the term "de-commercialize" does not mean *no* commercialism. Some is necessary, and is good, but like the merry-making that quite naturally goes with the celebration of anyone's birthday, it should be in moderation. Christ, Whose birthday it is, should take first place — not be excluded from the minds and hearts of those who are celebrating.

Last year, it became a project of the 85 students of St. Michael's School of Nursing, to introduce the "Bring Back Christ To Christmas" campaign

(Lethbridge Herald)

Making Posters.

(Lethbridge Herald Photo)

Nativity Scene

to Lethbridge, Alberta. Activities started early in October, when various students of many faiths, volunteered for the planned phases of the campaign. Local postal authorities were approached and arrangements were made for the purchase of a die slug for the cancelling machine. This stamped the slogan "Let's Put Christ Back Into Christmas" on outgoing letters from the Lethbridge post office. Utmost co-operation and interest were shown by all concerned. The stamp was used from December 1-24.

Another group of volunteers visited numerous stores and business firms in the city. They suggested the use of Christian motifs in the Christmas decorations. They also requested permission to display appropriate posters. Again, the nurses and their idea were graciously and enthusiastically received. The result was 30 posters, hand-painted and printed by the busy girls-in-training, proclaiming and reminding the shopping public that "Christmas is Christ's Birthday."

One of the "Here's How" suggestions on the leaflets distributed by Mount St. Vincent College, Halifax, read: "Place a Christmas crib in your home — under the Christmas Tree." The student nurses of St. Michael's decided to have an outdoor Nativity scene in front of their residence. They already had a very beautiful one inside the building. Patterns were obtained for nine life-size figures and a shelter. Donations of plywood, paint and "technical advice" were solicited. Finally, many long, enjoyable hours were spent in planning and producing their outdoor Christmas crib, complete with flood lights and recorded carols.

(Lethbridge Herald)

Amateur Carpenters

Miss Walshe is the president of the class of '59, St. Michael's General Hospital, Lethbridge, Alberta.

Passers-by became well acquainted with the colorful scene depicting the Divine Infant and His Mother, surrounded by St. Joseph, a shepherd and his animals, and the three wisemen. Above the shelter hovered an angelic figure and the bright, shining Star of Bethlehem.

Generous publicity through word and picture was accorded the campaign by local television, radio, and press facilities. Besides on-the-spot moving pictures of the nurses at work on the posters and crib figures, two of the girls were interviewed on a television program.

The results of the student's efforts to bring back Christ to Christmas are largely in the realm of the intangible. Posters, slogans and outdoor cribs are not ends in themselves, but only the means to an end — that people should be reminded of the true meaning of Christmas, Christ's birthday. After "first things have been put first," all the joys and merriment of the holiday season can be *true joys*, with assurances of a truly Happy New Year ahead.

Many other ideas and suggestions are planned for this year's campaign. It is hoped by the students of St. Michael's that they will be joined in their efforts by other schools of nursing throughout Canada. A similar program has been carried on for the past two years by St. Joseph's School of Nursing in Glace Bay, Nova Scotia. May the year 1958 see many more Canadian student nurses participating generously in this nation-wide, interdenominational campaign, to "Bring Back Christ To Christmas."

JEANNE WALSHE

How Can the Nurse Understand Herself?

KENNETH A. HAMILTON, M.B., F.R.C.P.

"KNOW THY SELFE." This admonition, that is often quoted, is attributed to Sir Thomas Elyot (1490-1546). He wrote and printed the first treatise on education in 1531. He was a scholar of high repute and was one of Henry VIII's diplomats.

Pure science studies the phenomena of nature. In doing so it uses the methods of ordinary, everyday observation, albeit the techniques of applying the senses to the problem may be highly refined and complicated. Pure science by its strictly objective methods can understand and predict behavior of physical matter under varying conditions. It has established, over the years, a code of laws of nature that can be applied and from which consistent results will always obtain.

Psychology also uses objective observation. The behavioristic school of this subject limits its methods to objective technique, thus trying to emulate pure science. But human psychology uses yet another method of study which is called *identification* or *introspection*. The subject for study and the student are both human personalities, thus the student can introspect his material, look within it or, in other words, place himself by means of his imagination in the situation that is under consideration. This ability to imagine oneself in the same situation as another and consider how one would react oneself is called *identification*. When the psychological observer, having identified himself with his subject not only considers and reasons about him in his situation but is also able to react with understanding and feeling, the process is known as *empathy*.

When one is called upon to interest oneself in another person's motives and behavior in a setting of industry or anywhere else, it is necessary to take note of what that person does, says and looks like. This is

Dr. Hamilton, who is an internist on the staff of the University of Alberta, presented this address at a meeting of the occupational health nurses of Western Canada at Banff last spring.

the objective side of the study in which movements, facial expressions, tone of voice and content of speech are taken into consideration. In addition, however, an interested student of personality must use his powers of introspection and identify himself with his subject. He must think of what he would feel and do if he were in that other person's shoes.

If the occupational nurse is to be competent to make valid judgments about her charges, she must identify herself with each of them as the occasion arises. She should be able to empathize or enter into the other person's feelings. It is also essential that this nurse should have as full a knowledge of herself as possible. How is she going to acquire this knowledge? She can do this by seeking knowledge about human personality, its origins, growth and development. All psychoanalytical schools of psychiatry give courses in this subject which is known as *personology*. It is the basis for psychoanalysis and gives insight into the development and growth of the human personality from early infancy to and through maturity. The best way to acquire thorough self-knowledge would be to undergo a psychoanalysis oneself. Every psychoanalyst has to do this to qualify for the practice of his profession. Unfortunately, facilities for psychoanalysis are limited, not to mention the fact they are expensive in money and time.

Let us try to sketch what personology is all about. The infant is born with certain inherited physical and emotional tendencies. As he goes through his childhood, his growth of body and mind is conditioned by the pressures of his environment. At birth he will have certain emotional tendencies. He may be a sensitive infant who responds vigorously or aggressively to the stimuli of his infant environment such as light, sound, cold or movement. On the other hand, he may seem to be born less responsive or phlegmatic with passive tendencies. Aggressivity and passivity are two opposite basic personality traits and most people can be classified in terms of these concepts. Our niche in life will, in large part, be determined by how much one or the other trait motivates us.

As the infant grows through his childhood, he is subjected to the conditions and demands of his family which in turn are determined by the cultural conditions in which that family finds itself. In our culture, it is advisable if not essential, that a child should grow up with two parents so that he may have the opportunity of identifying himself with each of them. Thus he acquires personality and character traits for better or for worse. Our professional educators, legislators and religious teachers try hard to establish the standards for human conduct. They establish an ideal norm for behavior by exerting constant pressure and demands upon adult society which in turn are passed on to the children.

Infants and growing children are highly susceptible to suggestion and as a result of the pressures and demands of the family, their basic personalities are crystallized out by the age of seven. In other words, the pattern of emotional reaction that will be followed thereafter is laid down at that early age. It may be modified later, but it will not be drastically changed except perhaps through a long and tedious psychoanalysis.

For purposes of didactic reasoning, the human mind or *personality* is believed to have three functional or *dynamic* parts. Plato and Aristotle spoke of this tripartite structure. We are all aware of that part which we ordinarily call *the self* or conscious intelligence. This part is known as the *ego*. It is the part or function of the personality that is in closest contact with physical and social reality all around us. It enables us to contact and learn about our environment and to react to reality. The ego (or "I" part of us) directs our behavior in a way that is consistent with physical and social reality. Many of us without much knowledge of how we are mentally constituted make the mistake of thinking that there is nothing else to us but ego and that all our decisions and actions are the result of ego-function or self-determination.

The second part of our personality organization has been called the *Id*. This is a neutral name, the German for "It." When we are born, we have nothing else but id. Ego evolves as we grow out of infancy and learn

about the social and physical world about us. The id part of us is the source of our psychobiologic energy. It is concerned only with strivings for pleasure and gives us the aggression we need to fulfill our wishes. It is concerned only with our needs for pleasure and motivates aggression toward that goal. Id has no idea of time or of reality and is concerned only with goals set up by our loves and hates.

Id impulses are controlled by ego which keeps our behavior within the bounds of reason and reality. Without ego controlling id, we should be neither adult nor civilized but would live in a timeless world of immediate sensory satisfaction or discomfort. The infant is all id and so are many psychotic patients. We speak of ego weakness and when we do, we mean that behavior is determined by the pleasure principle, impulsive, antisocial and irresponsible. Persons of this make-up are classified as *psychopathic personalities.*

There is yet another third function of the mind which is called the *super-ego.* It is the force within us that makes us social beings within our particular cultural set-up. Super-ego starts to develop the first time mother says no. It incorporates morality and directs us according to the rules of our social organization. As a result of it, we accept responsibility. It might be equated with conscience. It is the voice within that governs our behavior according to the moral standards of our society. It is the voice of that society, of the parents and also of the teacher, the clergyman and the policeman.

The following is an example of how these three functions of the mind might operate. A feeling arises. "I should like to kiss that girl — it would be a very pleasant experience," says id. "But I won't do it right now because she might rebuff me with so many people around. The time and place are not propitious," says ego, in contact with reality. And then super-ego interjects, "You should not do that at all because it's not done to go around kissing strangers on impulse." Of course, a few too many cocktails would put super-ego and ego into the discard. Conflicts arising from interplay of these three mental forces are always occurring and lead us into emotional distresses and symptoms.

Ego, id and super-ego are dynamic or functional concepts but *the mind is also divisible topographically* into two regions or parts. These are the *conscious* and the *unconscious* parts. The conscious part of the mind has to do with immediate awareness — at this time — right now. But there is also a vast content of our minds about which we are not aware right now. This is the unconscious part of the mind or just "the unconscious." From the unconscious we can, with effort, call up a certain amount of material such as names, dates and reminiscences as occasion may demand. But there is also a vast mental storehouse full of past experience within our minds that we cannot call up. This storehouse contains wishes, strivings and ideas that once were conscious but which have lapsed into unconsciousness. Also there are many wishes and desires within the unconscious that belong to the inherited id and of which we never were conscious.

Unconscious mental activity can be brought to consciousness by employing the techniques of *hypnosis and psychoanalysis.* The aim of psychoanalysis is to bring up our unconscious wishes, desires and ideas and make them conscious. Unconscious material thus exposed can be seen, accepted and handled in an effective manner. Only thus you are truly enabled to "know thy selfe." Probably few of us even suspect that the influences of our unconscious mind, with its inherited id forces and wishes as well as those derived from past experiences, have so much to do with our behavior. Nevertheless, psychology and psychiatry have shown that much of what we think, feel and do is determined by unconscious mental processes.

As we grow up from infancy through childhood and into adult life, we are all beset by the psychopathological disturbance that is known as *anxiety.* Anxiety is universal. It begins in infancy the first time we are permitted to go hungry or are left alone for too long. It troubles us all through life and motivates our strivings and demands for security, wealth, prestige

and the like. It is a variant of fear and it is highly discomforting. It stems from conflict — unconscious mostly.

By the study of *the defences that we put up to reduce our anxiety,* we can learn much about ourselves and others. We label these psychological defences with the names of mechanisms.

Rationalization: To rationalize means "to make rational." We all rationalize. When we do this, we select the most acceptable of a mixture of motives to explain our behavior and we deny, repress, or put away from our consciousness the less desirable motives. A person helps a friend and is asked, "Why did you do that for him?" He replies, "I did it out of loyalty and feeling for him" whereas the truth was probably not quite so altruistic. "I did it because I felt under an obligation to him and besides I hoped that at some time he might help me and also I wanted to feel superior to him."

A wealthy man gives money to a cancer fund, he says, because his wife died of cancer. But he also wanted to do something for the community from which he got his money. This act in turn would relieve his feelings of guilt and anxiety on account of his ruthless business methods. His generosity would be publicized and he would be the object of public admiration. He puts away or represses many of his selfish motives into unconsciousness because it would hurt him to accept them, although they are normal human ones.

Alcoholics are great rationalizers. They drink, knowing too well its harmfulness, because they say their wives are hard to live with or because they want to celebrate properly someone's promotion or for a thousand reasons except the real one. They like to drink for the comfort and well-being that comes before the hangover!

Projection: Unconscious hostile feelings and wishes tend to rouse anxiety. They are often handled by use of the mechanism called projection so that the hostility is attributed to someone else. Thus the emotional problem is resolved by the thought, "I do not want to attack him; he wants to attack me." This mechanism is the basis of the delusion of persecution. Projection protects us from the results of our own hate and hostility by attributing it to others.

Displacement: By use of this mechanism we transfer emotion from one subject to another. A reprimand from our boss at work rouses a hostile emotion, but we can not talk back to him without risking dismissal. So we come home and displace this emotion on the wife or the children or the dog or all of them.

Similarly, *unconscious hostile feelings may be turned against the self.* "I hate him" if unacceptable to the conscious ego may be turned into "I hate myself." The reason is that unconscious thoughts and feelings of hatred toward a loved one arouse guilt and anxiety and these painful feelings are relieved if directed against the self. The turning of hostile feelings against the self is a feature of depressions.

Reaction formation (overcompensation): This mechanism entails the development of attitudes or character traits exactly opposite to those against which they protect one. Unconscious feelings of cruelty may be kept unconscious by an exaggerated concern for the suffering of others. Unconscious aggressive tendencies may be kept unconscious and anxiety thus avoided by over-development of submissiveness and humility. Unconscious prurience of mind can be held in check by assumption of the role of vice crusader.

Regression: This mechanism results in a return to an earlier more childish form of feeling, thinking and behavior. It consists of a flight back into childhood. Under stress people regress.

Sublimation: This consists of the substitution of socially acceptable behavior for that which is not. Competitive games represent sublimation of combat. Boxing is a very superficial sublimation of hostile, all out to the death, individual combat. Football — American type — is a sublimation of organized warlike combat. The word sublimation means "to transmute into something nobler or more excellent."

Transference: A patient comes for help to someone in whom he places confidence. In so doing he puts himself in a dependent relationship. He may compensate for this dependency by aggressiveness toward the one from whom he seeks help. Thus the transference relationship presents positive or negative qualities from time to time.

Before finishing this discussion about how the nurse may understand herself,

some enlightenment about the nature of mental illness would be in order.

Insanity, psychosis or severe neurosis is not something that gets into our patient. Its germs have been there all that person's life. *Mental disorder is not qualitatively different to normal mental activity. It is only quantitatively different.* If the nurse will introspect and look within herself, she will recognize that she experiences, from time to time, unaccountable changes of mood and energy. Such changes are similar to those of *manio-depressive illness*. In all so-called normal persons, the changes of our mood and energy are transient. We have our days of high spirits and exuberant energy with productive output which corresponds to a short-lived manic phase. We also have our days of low-spiritedness with lack of energy and poor productive output which corresponds to a short-lived depressive phase. The manic depressive's phases of being up and being down are longer and more intense. Those are the only differences.

The nurse should take notice of the fact that she may have a *habit of ascribing failure and disappointment* to the actions of others, when she should recognize that the fault is her's alone. If she does this, she will recognize the mechanism of *projection* which distorts the behavior of *the paranoid person*. The difference is that the normal person thinks like this only from time to time while the paranoid person thinks that way all the time throughout the course of his chronic illness. Daydreams in which satisfaction is obtained are normal. Who does not fantasy what life might be like after winning the Irish sweepstake? Such daydreams are not qualitatively different from those entertained all the time by the schizophrenic person.

Finally, the nurse must have recognized various somatic symptoms in herself that she has used as excuses for retreat from difficult or unpleasant situations. If she can recognize such disorders of her own mental activity, she will find it easier to understand the symptoms, behavior, and motives of her patients.

What Each Expects of Nursing Education

The Doctor

J. A. I. MacMillan, M.D.

FROM THE POINT OF VIEW of the medical profession, opinion seems to vary concerning nursing education all the way from those who consider that nurses are not getting enough training to those who believe that they are getting too much. The latter group feel that nurses are becoming too scientific-minded and are not enough concerned with the patients they are attending. They feel that there is an increasing tendency to consider the patients as cases and not as individuals. This latter objection is one which unfortunately has some basis in fact and is to be deplored.

What is considered basic training for a nursing career? It is certain that a nurse must possess certain basic qualities — innate traits besides those qualities usually associated with the female personality. Sir William Osler has listed the following virtues as basic — "tact, tidiness, taciturnity, sympathy, gentleness, cheerfulness, all linked together by charity."

These, then, are things to be looked for in prospective applicants to any nursing school. Not every one is endowed with the peculiar sense necessary to undertake the care of the sick. Those who enter nursing with an idealistic attitude are few and far between. Most young women enter because it offers a certain security and independence; others, because nursing offers a vocation on a small budget; and a few enter purely on the urging of relatives and friends who may or

Dr. MacMillan gave this address as part of a panel discussion on nurse education at a chapter meeting of the N.B.A.R.N., Newcastle.

may not have had experience in the field. Then there are still others who enter for reasons known only to themselves. Reasons why are not important. It is what the school turns out that *is* important.

Once enrolled in the school the official training is initiated in the protection of the classroom. At the present time, high school leaving or junior matriculation is commonly required for entrance. This is a good foundation to start from. Basic lectures in the sciences, anatomy, physiology, and patient care are begun. Here we run into one of the main sources of argument. Medicine has advanced by terrific strides in the last 50 years or more. The whole concept of diagnosis and treatment has changed radically from the days of Lister and the introduction of the theory of antisepsis. It has become a rather exact science with certain rules and regulations that are well accepted and standardized. But has nursing education kept pace with the advances in medical treatment? There is a large group in the medical profession who feel they have not, and a still larger group feel they need not.

This latter group express the opinion that the nurse's duty is to nurse — to provide for the patient's physical comfort and to carry out prescribed treatment without any need to know why she does it. They have apparently lost sight of the female quality of inquisitiveness if they expect the general run of nurses to accept this state of affairs without question.

It would seem to be an ideal situation to have the nurse as familiar as possible with the theory behind the various treatment methods. Only in this way can the end result of treatment be improved. Only in this way can the nurse be on the lookout for an unfavorable change in the general condition of the patient. Thus it would seem advisable to provide as much instruction as is feasible in dealing with the whys and wherefores of such procedures as intravenous therapy, anticoagulants, antibiotics, oxygen and croup tents, spinal taps, paracentesis and thoracentesis. This may seem like specialized work but it is the general duty nurse or the floor supervisor who assists the physician in these procedures, not specially trained technical experts. A certain amount of instruction or at least an introduction to these adjuncts in therapy would not appear to be amiss.

In the first year of training the student is introduced to hospital routine. It is during this period that the qualities of a good nurse are developed. One bad feature of this particular period is that the hospital administration has too much call on the students' time. In fact hospitals tend to lean too heavily on their student nurses for the successful running of the floors. It is probably during this time that most students are lost to the school. Those unable to take the menial duties drop out and their more hardy sisters carry on. This leads to the employment of practical nurses and ward aides.

In the second and third years, the student learns to accept responsibility in dealing with medications and following the progress of patients throughout their stay in hospital. It is during this time that the theory of nursing is transformed into practice and the pattern of the individual nurse's performance is laid. This responsibility would appear, from personal observation at least, to be better developed in the small hospital rather than in the larger schools. This is a natural consequence because it follows that the fewer trainees there are the more jobs the individual must be exposed to and, by repetition, becomes capable of performing.

It is at the graduate level that most change has taken place in nursing education. The individual's personal choice of work must be met — medical or surgical nursing, operating room, case room, private nursing, laboratory or X-ray work, and the fields outside the hospital such as the V.O.N., public health branches, occupational and home nursing. Unfortunately for the hospitals and fortunately for some of us, a very high percentage of the graduates are almost immediately absorbed in the domestic field and, as a general rule, are lost to the profession. I suppose this might be considered a natural hazard and should be accepted gracefully and without malice by the hospital authorities.

Speaking in general terms, doctors feel that the type of training in the present school of nursing is good, but

they also feel that the depth of the training could be improved. This, then, presents a challenge to the nursing instructors and to the teaching supervisors on the floor. The quality of the nurse produced by any school depends on the training, knowledge and example set by the instructors as much as on their own innate capabilities.

I have read a copy of the report by Miss Kathleen Russell on nursing education in New Brunswick, and have been impressed by the intensity of the research done and the various avenues explored and discussed. This report should be read by all nurses, since it concerns their profession and its future. As to some of the recommendations, I would deplore too complete a separation of the school of nursing and hospital administration. I have never known a business to run smoothly under two heads excepts in those very exceptional circumstances that occur too rarely to be depended upon. Postgraduate training for those who wish it should be made available and attractive, subsidized if necessary, and given at the university level.

Concerning the use of practical nurses and ward aides — they have their place but I do not think it is in the hospital. There is a tendency to depend too much on this type of training. This may be done for purely financial reasons but it results in inadequate nursing. They tend to take and are given more responsibility than they are trained to handle. They can be useful in home nursing where financial difficulty prevents the use of special nurses. Their employment in hospitals usurps the field of the nurse to the extent that she does not get to know her patients well enough and does not perform her duty to those patients.

In the day-to-day hospital routine and in discussing nursing in general we tend to forget that the ideal of nursing is the patient's welfare. Anything the nurse can do to improve this will bring us closer to performing a real service to those entrusted to our care. Nursing began as charity. The day this charity is lost will be a sad day for nursing, and indeed for all of us.

Give us a nurse we can depend on — one who is tactful, responsible, sympathetic, devoted to duty, cheerful, respectful and capable. Give her a broad basic education in general nursing procedures; give her an understanding of active therapeutic and preventive principles, and help her to procure special training in postgraduate work for the more specialized methods of treatment if she should want it. Do this by whatever method you like — standardized curricula for all schools with university trained instructors, independent schools, or university degree courses — the method does not concern us, the product turned out *does*.

The Head Nurse

PAULINE ALLISON

AS A HEAD NURSE, I expect the new graduate, with her basic education, to understand the patient and to think of him or her, as an individual, each with his own idiosyncrasies and not as the leg in Room 20 or the eye in Room 25. She would be able to assume responsibility; to take charge of the ward during my absence; to see that all routine work of the department is completed; to meet an emergency calmly and intelligently and to use her own initiative when necessary.

A graduate nurse should have a good basic knowledge of all procedures, even rare ones, and be able to carry them out correctly in a confident manner. She should be able to explain the procedure to the student in such

Miss Allison was a laboratory technician and Assistant Supervisor in the Outpatient Department, Miramichi Hospital, Newcastle, when she gave this paper.

a manner that the student will understand the reason for it.

Her knowledge of drugs should be extensive enough for her to know the correct ways of administering them and what effect they will have so that she can intelligently report the physician in charge of the patient if the patient is not reacting as expected and when the medication is causing allergic or toxic symptoms. This is one time when her powers of observation are especially important. She should be able to make rounds with the doctors; to take their orders correctly; and to give the physician an accurate report of the patient, his symptoms and response to treatment.

She may not realize it, but the graduate nurse is always teaching, either well or poorly. She should set an example to the younger nurses by not taking short cuts. She is also teaching the patient good or bad habits by example, namely, good personal hygiene. Her mind must never be closed to learning. Every day someone teaches us something.

The Student

ELEANOR TOZER

WHEN I CHOSE NURSING as a profession, I knew very little of what to expect. My idea was the ideal — the white starched uniform, the confident appearance that I had developed from reading articles and studying portraits of nurses. My first bubble burst when I discovered that black shoes and stockings, not spotless white, were in store for me. Following this were more disillusionments — studying to do, bedpans and enemas to give and blood-spattered uniforms. It was only after I had started my nursing course that I realized that I was not only nursing the physical person but that there was a mental and spiritual side to nursing as well.

I remember reading a line that went something like this — "Each day is a little life." In each day of my nursing career I have lived a little life and in living it I have learned many things and have acquired many qualities. I have found that it gives a person deep satisfaction and peace of mind to work for others, not out of duty but out of love of duty. One is not always fortunate enough to have the ideal person for a patient. On the contrary, there are the crabby, spleeny patients and the ones with a bad case of "gimmies." However, we learn to overlook this at the time and to try to relieve pain and ease their mental depression with kindness and understanding.

I have received much from nursing experience not be measured in material things. It is a way of life, an understanding of the world and the people in it. This not what I expected when I entered nursing because I knew not what to expect. I had only the vision of my ideal which turned out to be less glamorous than anticipated. What I have received from my nursing course will surpass the vision.

Miss Tozer graduated from Miramichi Hospital in October 1956 and was doing general duty there when she presented this talk.

I was figuring on starting some kind of a business, but most every business is already engaged in more than's necessary; and then I ain't got no business ability. What I want is something that don't call for no kind of ability whatsoever and no kind of exertion to speak of, and ain't out of town, and pays good, and has a future.

—Author unidentified

The happiest conversation is that of which nothing is distinctly remembered, but a general effect of pleasing impression.

—SAMUEL JOHNSON

* * *

Individuality is the salt of common life. You may have to live in a crowd but you do not have to live like it nor subsist on its food.

—HENRY VAN DYKE

Dear Doctor Atlee:

Doctor Atlee has for so long been a friend to nurses and to nursing education that one hesitates to challenge him on any point. This writer, however, agrees with him so heartily that nursing education in many schools in Canada is a farce and that something must jolt these schools out of their rut "into the facts of modern nursing" that this letter is sent in the hope that a stimulating correspondence in regard to the real nature of the problem will ensue in *The Canadian Nurse*.

Many things that Doctor Atlee says seem to this writer to be just and valid. It is true that in all too many schools the instructors are divorced or almost divorced from the actual nursing of patients and live in ivory towers, teaching something out of their own past or, at best, the current books; that undergraduate nurses are being taught many theoretical subjects without grasping the relationship of these to nursing practice; that the service personal feels little or no responsibility for the education personnel and students, and that a great barrier tends to grow up between the two; that the top nurses are usually the best ones but they are often relegated to telephone answering and form-filling, leaving the care of patients to unsupervised undergraduates and less qualified graduates; that the undergraduate experience on wards is frequently uncoordinated with the theory being taught in the classrooms, and the theory at variance with the ward practice; that the undergraduate experience is too often unsystematic because subject to the exigencies of hospital service.

But granted all these things, is Doctor Atlee's assessment of the basic problem correct and, if so, will his solution solve the problem? Is the basic problem that the undergraduates are not being taught to nurse the patients, because they are not taught by practising nurses, preferably head nurses? And is the solution to put this teaching into the hands of head nurses and their immediate assistants, paying them for their dual role? Would this, with some major or minor reorganization of hospitals to keep nurses and undergraduates together on the same wards for some agreed length of time, solve the problem?

This writer agrees that all too often the undergraduates are not being taught to nurse the patients, but does not agree that this could be overcome by putting the teaching into the hands of the charge nurses. In fact, the very example that Doctor Atlee cites of the disputed use of the metal catheter, itself defeats his argument. There is simply too much knowledge available in the field of nursing, and too many techniques, procedures and types of equipment and medical opinions as to their relative merits, for the undergraduate nurse to be taught specific techniques and procedures on the ward even by the best of head nurses. Knowledge and equipment and opinions and the state of the world change too rapidly for that. These undergraduates must be taught general underlying scientific principles in the classroom by nurses who are themselves abreast of the best theory and practice, and who are, in addition, good teachers. This theory must be illustrated to each undergraduate first by observation of good nursing on the wards and then by practice, under supervision, also on the wards. Ideally, such teaching, observation and practice will be under the charge of the same instructor.

This demands a great deal of the instructor. She must, as has been said, be and keep abreast of the field, and be a good teacher. As well as imparting knowledge and developing skill she must be able to help students to attain independence of thought and action and mature self-discipline.

This also demands a great deal of any hospital. It must be prepared to find and to pay such instructors, give them access to the wards, and that status in the hospital hierarchy that is in keeping with, and will enable them to do, this difficult job of coordinating theory and practice. It must be prepared to take only the number of undergraduates it can teach and provide with adequate clinical observation and experience.

Is this not asking too much of any hospital? The chief function of a hospital is to care for patients, and students should and must always come a poor second. To this writer this duality of purpose is the crux of the problem, and will be resolved only when hospitals staff their wards with paid staff and schools of nursing are freed from the demands of nursing service. Schools of nursing must obviously use hospitals for their clinical experience as do medical schools: whether or not schools of nursing should be on the hospital premises is beside the point: it would be convenient to be close by, but what *is* essential is that their main purpose be education.

This suggestion is always met with the same cry, "But who will nurse the patients?" The answer to this is, nurses should nurse the patients with the help of nursing assistants, aides, maids and other auxiliary personnel. To all the suggestions Doctor Atlee outlines for freeing nurses to nurse, this writer would add that hospitals, wards, equipment and procedures could be streamlined in such a way as to greatly save the time, energy and strength of nurses. No doubt there would be a difficult period of adjustment to face if there were any sudden move to reform all schools of nursing at once. This, however, is no more desirable than feasible, for we do not know what changes to make. Though gallons of ink, reams of paper, and a great deal of human emotion have gone into debating this question in the past few years, relatively little calm objective reasoning has gone into experimentation, and even less has been done to follow up the experiments already undertaken.

In the meantime the crisis of national health insurance is almost upon us. This writer would suggest that nurses, through their national and provincial organizations, their provincial departments of health and welfare, and the federal department of health, and with the help of any interested foundations, industries, and private citizens, undertake a nation-wide series of experiments-in-action, in which the many suggestions proffered, including Doctor Atlee's, be tried out under conditions of controlled research with a view to devising a method or methods of educating nurses that will meet the needs of this expanding nation.

MURIEL UPRICHARD, M.A., Ph.D.

Dr. Uprichard is on the faculty of the School of Nursing, University of Toronto.

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The article is the most commonsense and worthwhile I have read in some time. If a few more thought as Dr. Atlee, it might help matters, and not only in training schools.

HELEN T. HUTCHISON
Toronto, Ont.

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Right or wrong, Dr. Atlee is very sincere and is thinking of the welfare of the patients, quite naturally. It would be ideal if every head nurse were required to have a year at university to qualify as an instructor; then, of course, to be reimbursed accordingly.

Dr. Atlee's idea of providing clerical help is not new but certainly is sound. As for the "dummies" in the classroom, that is one matter upon which he certainly is not qualified to speak. He knows very little about it and can't begin to imagine what the students, be they ever so bright, would be like without the grand nurse-teachers in the classroom.

ELINOR M. PALLISER,
Shediac, N.B.

In Memoriam

Isabel (MacAulay) Bryant who graduated from the Sherbrooke Hospital, Sherbrooke in 1928, died on September 28, 1957 after a lengthy illness.

* * *

Charlotte (McCallum) Duval, the first nurse to go to the Queen Charlotte Islands, B.C., died recently in Queen Charlotte City. She was 78 years of age. Mrs. Duval practised her profession in Edmonton and Winnipeg before coming to the Islands in 1911 where she gave many years of devoted service.

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Germaine (Brosseau) Curot, infirmière diplômée de l'Hôpital Ste-Justine en 1910, est décédée récemment. Elle fut la première infirmière du Service de Santé de Montréal, poste qu'elle occupa de 1914 à 1921. Présidente de son amicale en 1929, Mme Curot organisa l'association des anciennes de Ste-Justine sur des bases solides. Infirmière dévouée et femme de devoir, ainsi peut se résumer sa vie.

* * *

Florence M. (Davis) Krossa who graduated from the Toronto General Hospital in 1913, died in Livonia, Michigan on July 3, 1957.

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Gladys (Clark) Morrow, a graduate of a Winnipeg hospital who did private nursing in Moosomin district for some time, died in September, 1957 in Moosomin, Sask.

* * *

Maud (Webb) Wilson who graduated from the Toronto General Hospital in 1914, died in Toronto on August 27, 1957.

Everything that enlarges the sphere of human powers, that shows man he can do what he thought he could not do, is valuable.

—SAMUEL JOHNSON

Rôle de l'Oxygène dans la Physiologie

JEAN PHANEUF, M.D.

L'HISTOIRE, pour éclaircir le phénomène de la respiration a passé par plusieurs étapes avant d'arriver aux connaissances actuelles. Des progrès réels ne purent être faits qu'après la découverte de la circulation sanguine par Harvey en 1615. Il a fallu des siècles pour établir ce rôle primordial de l'oxygène à la vie, démontrer son existence, prouver que la voie d'accès dans l'organisme se trouvait dans les poumons, que le sang était le véhicule, que sa présence était essentielle à la production d'énergie et à l'entretien de la vie.

On peut diviser la fonction respiratoire chez l'homme en deux parties:

1. La respiration externe ou ventilatoire qui est l'échange des gaz en passant dans l'arbre respiratoire avec le sang. Cet échange se fait au travers des parois alvéolaires et capillaires par la différence de tension entre les gaz alvéolaires et le sang.

2. La respiration interne qui est l'échange des gaz entre le sang et les tissus.

La fonction respiratoire assure à l'organisme l'apport de l'oxygène nécessaire à la vie et contribue en éliminant le carbone dioxide au maintien de l'équilibre acide-base. Les symptômes qui accompagnent le besoin en oxygène ressemblent à ceux de l'intoxication alcoolique:

Agitation, loquacité, anxiété; le jugement est diminué et peut dégénérer en état de délire. Au point de vue subjectif, la plupart des patients accusent une céphalée plus ou moins grave; il peut y avoir de l'étourdissement, de la transpiration. Très souvent il existe une douleur précordiale identique à celle rencontrée dans les cas d'angine de poitrine.

Les changements dans la respiration sont peu évidents mais aboutissent à l'arrêt respiratoire. Le pouls s'accélère proportionnellement à la réduction du pourcentage de saturation en oxygène, et si le besoin en oxygène s'aggrave, le pouls se ralentit et le coeur entre en fibrillation. Les téguments peuvent être pâles ou cyanotiques et couverts de sueurs.

Haldane a décrit succintement l'effet de l'anoxie sur l'organisme: "L'anoxie, non seulement arrête la machine mais en détruit le mécanisme." Les effets sur la destruction du mécanisme apparaissent dans les dommages faits aux cellules et aux tissus. Les organes le plus souvent atteints sont par ordre de sensibilité: le cerveau, les surrénales, le coeur, les reins, le foie.

Un arrêt circulatoire complet de trois à huit minutes cause une destruction des cellules pyramidales du cortex cérébral. Mais il faut se rappeler qu'une anoxie non complète mais prolongée peut avoir des résultats désastreux, par exemple, dans les états de shock, postopératoires ou autres, chez les nouveau-nés.

Les effets sur le système cardiovasculaire sont importants parce qu'ils aboutissent à une chute de la pression artérielle, une accélération du pouls, un ralentissement de la circulation qui aggravent encore plus les besoins de l'organisme.

Les effets sur les poumons sont néfastes parce qu'ils augmentent la perméabilité capillaire et produisent une accumulation de liquide lymphatique dans les alvéoles qui ralentit les échanges d'oxygène et de CO_2. Quelles sont les indications:

L'oxygène est un moyen thérapeutique qui a peut-être été trop longtemps réservé aux moribonds. Si on se rappelle que l'organisme ne peut s'en passer même pour quelques minutes, il devient essentiel d'en donner dans tous les cas d'anoxie aiguë. Dans les cas de maladies chroniques, on peut se demander si une saturation complète du sang artériel est essentielle à une bonne santé. Cependant il faut s'en rapporter d'abord à la cause. Quelquefois la correction immédiate de la cause dans les cas d'obstruction mécanique peut être suffisante, soit par élévation de la mâ-

Dr. Phaneuf est l'anesthésiologiste à l'Hôpital St-Charles, St-Hyacinthe.

choire, par introduction d'une canule oropharyngée ou un tube endotrachéal, l'aspiration de sécrétions, régurgitations ou vomissements.

Dans les cas d'hémorragie ou de shock, l'administration sans délai de sang ou le sérum est essentielle pour rétablir au plus tôt la masse sanguine, améliorer la circulation et augmenter le taux de l'hémoglobine qui est le véhicule principal de l'oxygène. Chez ces patients, l'administration d'oxygène soit par cathétère nasal ou au masque, est indiquée tant que la cause n'a pas été corrigée pour prévenir l'aggravation de cet état. Chez ces patients il faut se rappeler que deux critères importants aident à préciser la gravité de cet état : la pression artérielle et la vitesse du pouls qui doivent être notées fréquemment.

Chez ceux qui souffrent d'anoxie pour une raison liée aux poumons, le traitement doit être orienté vers la cause ; chez ceux qui souffrent de défaillance cardiaque, en améliorant la circulation ; dans la pneumonie par un traitement chémothérapique. Dans ces cas, l'oxygène donné dès le début prévient une aggravation et l'installation de troubles réversibles.

Y a-t-il possibilité de nuire aux patients en donnant de l'oxygène ? Il faut se rappeler que l'oxygène donné à haute concentration tend à remplacer l'azote qui se trouve en solution dans le corps humain. Par exemple, si les poumons sont remplis d'oxygène dans les traitements postopératoires et que des alvéoles se bouchent, l'oxygène est rapidement absorbé, les alvéoles se collabent et donnent lieu à de l'atélectasie.

Un autre danger peut apparaître lorsque les mécanismes régulateurs normaux de la respiration sont modifiés par les agents anesthésiques, les barbituriques, la morphine. Donner de l'oxygène dans ces cas peut être suivi d'apnée et il faut avoir recours à la respiration artificielle.

Le même danger peut se présenter occasionnellement chez les emphysémateux.

En dernier lieu, mentionnons l'empoisonnement à l'oxygène qui se rencontre dans les traitements prolongés avec des concentrations de 70 pourcentage et plus, mais qui a peu de chances de se produire dans les conditions cliniques ordinaires. Mentionnons également la cécité qui peut apparaître chez les bébés prématurés demeurant dans les incubateurs de façon prolongée et respirant des concentrations d'oxygène de 50 pourcentage et plus.

If man had never gotten up off all fours and learned to walk on his hind legs, he might not now suffer from varicose veins. Man's upright stance makes it necessary for the blood in the lower extremities to flow back to the heart against the pull of gravity. In people who have inherited weak veins or whose occupation keeps them on their feet for long hours at a time the relatively thin-walled surface veins of the legs and their delicate valves are not always able to withstand the strain.

Some recommendations that doctors consider helpful for all patients with varicose veins are :

Avoid standing or sitting still in one place for long periods of time. This tends to make the blood stagnate in the lower part of the legs and may lead to complications.

On a train or plane trip, get out of your seat and walk about every half hour or so ; on a long car trip, stop now and then and stretch your legs.

When watching television, put your feet up on a stool ; get up and walk around at least once an hour. (If you can put your feet on the desk while you are working, so much the better for you.)

Exercise — especially walking, bicycling exercises and swimming — is of great help in improving circulation in the veins.

For women, round garters are taboo. They cut off the circulation and should never be worn. Elastic girdles interfere with circulation and should not be worn continuously, especially during long stretches of sitting. Women, incidentally, are more likely to suffer from varicose veins than men. The condition is especially common in women with a hereditary tendency who have had more than two pregnancies.

Sitting on a high stool with the feet resting on the top rung is good advice both for women doing household jobs in the kitchen and for men working at a bench. In this position the knees are bent, preventing the venous blood in the thighs from flowing back down the legs. —Amer. Heart Assoc.

RESEARCH

A More Wholesome Milieu

DOROTHY R. COLQUHOUN, B.A.

LAST YEAR the Curriculum Study Group of the Windsor-Essex County Chapter was organized at the request of the Educational Committee of the Registered Nurses' Association of Ontario as part of the project to give members, throughout the province, an opportunity to make their contribution to the revision of the Ontario curriculum for schools of nursing which is now under consideration. The terms of reference for the individual study group were that it could choose for study any area of the curriculum in which it was particularly interested, and that the term "curriculum" was interpreted in its widest sense. The Windsor-Essex group had representation from nursing service, nursing service administration, Victorian Order of Nurses, public health nursing service, industry, private duty and nursing education.

The group chose the following problem: "How can the school of nursing produce nurses with professional attributes?" This question was broken down into two aspects: (a) What are the professional characteristics that we wish to develop in students? (b) What experiences should the school curriculum provide that will help to develop these characteristics and, conversely, what experiences should be avoided since they interfere with the development of professional qualities?

The following characteristics were considered as being important and desirable:

1. Social consciousness, participation in, and a knowledge of community activities and agencies.
2. Group consciousness, support of and participation in the professional organization.
3. Emotional maturity, interpersonal relation skills, adaptability and flexibility.

It early became evident in the discussions that the onus of developing professional qualities could not be placed entirely upon the school of nursing and its curriculum but that graduate nurses and the professional organization had responsibilities in this area. It was impossible to discuss these matters without bringing in these two. Thus, two threads of thought will be found running through the recommendations and suggestions of the group, involving action on the part of both the school of nursing and the profession at large. The group found also that in discussing the development of professional characteristics there was considerable overlapping and that experiences which would foster one aspect would also function in developing others.

SOCIAL CONSCIOUSNESS AND COMMUNITY ACTIVITIES

In the consideration of participation in community activities, it was felt that there were two basic requirements:

The schools of nursing curriculum must be set up in such a manner as to provide time for nursing students to engage in outside pursuits.

Graduate nurses must make every effort to break down the idea, still prevalent in the community, that nurses have their interests channeled almost solely in their work and have little time or effort to devote to other activities.

Nurses, particularly those engaged in various areas of public health, have done much to overcome this idea but

Miss Colquhoun, who is director of the Metropolitan School of Nursing, Windsor, Ont., was chairman of the Curriculum Study Group, Windsor-Essex Chapter, District 1, R.N.A.O.

more needs to be done in involving institutional nurses, both graduate and student. The following specific suggestions were made with regard to activities in our own community:

1. That the Community Welfare Council be informed that representatives from institutions and student bodies would be interested in being included in the invitation to the Council's monthly luncheon.

2. That a representative from institutional nursing be on the Nutritional Council.

3. That the possibility be explored of having representatives from the Chapter and from the nursing school student organizations on the Local Council of Women.

Turning specifically to the school of nursing several suggestions were made. Students entering a school of nursing should be encouraged to continue activities engaged in during high school, such as, Girl Guides, C.G.I.T., Sunday School classes, music, etc. The clergy could be asked to invite nursing students to participate in church activities. A list of out-of-town students belonging to his denomination could be sent to each minister with the suggestion that individual members of the young people's organization could make themselves known to the students and personally sponsor them in the church group.

The study group then turned its attention to actual curriculum content having to do with the development of the appreciation of the health and social needs of patients, and the part played by the community in helping to meet their needs. The present Ontario curriculum has a course entitled "Health and Social Needs" with commendable and meaningful objectives. It was felt that the course as outlined was too detached from the nursing situation and that instead of being given as a separate course various parts of it should be included in other courses in the curriculum. It was recommended that:

1. The general objective of this course "to have the student learn to appreciate the health and social needs of individuals and how to help them to meet these needs" hould be included in all clinical courses.

2. The contributory objectives could be met in several courses, being most meaningfully taught in the following areas:

(a) Factors that favor the maintenance and promotion of health which are applicable both to the student and to the patient: Personal health.

(b) Significance of heredity and environment in relation to the development of the individual and his subsequent behavior: Sociology and Psychology.

(c) Effect of illness on the individual and on the family: Sociology and Psychology.

(d) Community resources available and how these may be used: Sociology and all clinical nursing courses.

(e) Principles and methods of teaching: Fundamentals of Nursing and Psychology.

In all clinical nursing courses the student should be helped to learn the effect of illness on the individual patient, his family and occupation; to assist the patient to adjust to his illness; to consider factors that may have precipitated the illness; to apply preventive measures; and to assist the patient in his social and physical rehabilitation. The student should have an opportunity to take part in the actual referral of patients to community agencies. It would be desirable for each student to make a follow-up visit with an agency worker to the home of a patient for whom she has cared. It was felt that more thought should be given to working out arrangements between the school of nursing and the health agencies to plan for this type of visit. Permitting the student to participate in referring patients to the community agencies would be a more meaningful experience to her than for a group of students to visit an agency.

Group Consciousness and Professional Organization

An active and democratic student nurses' association is of first importance since the school organization should be the training ground for participation in the professional organization upon graduation. Each student must feel that she is a part of her student organization and should be a working member. Attempts should be made to have enough committees so that each student would have the op-

portunity to serve on one of them. Suggested committees were: Social, recreational, finance, house, publicity, year book, school paper, interest groups, e.g. glee club, community activities. Students need help and stimulation from the outside and people who might assist in this would be alumnae members, members of the hospital women's auxiliaries, and local chapter members. The community activities committee could send delegates to annual meetings of community agencies, to the opening of new health and welfare institutions, and to meetings of the municipal council. Reports from this committee to the student body would help the student to become familiar with community activities and to feel a part of them.

When a school has developed a sound student organization, encouragement should then be given to the formation of an association of the various student organizations in the area.

There needs to be a closer relationship between the student organization and the professional organization. The group commended the work already being done in this regard by the Canadian Nurses' Association and the provincial associations in inviting student nurses to participate in the programs of the annual meetings. It was felt that there could be a more dynamic tie between the student organizations and the local chapters. At the local level this would involve more than inviting a group of students to one of the chapter meetings each year. There might be a professional liaison committee of the student organization which would keep in close contact with the work of the chapter and interpret the on-going functions of the organization to the student body. It was suggested that each year the student organizations in an area might be responsible for one of the programs of a chapter meeting.

The chapter should encourage the appointment of young graduates as committee members because of the contribution they could make to the chapter and the preparation this would afford as grooming for later executive positions.

It was felt that the individual graduate nurse could do much more towards helping the fledgling nurse feel that she is part of the profession. There continues to be a barrier between graduates and students in which the predominant attitude is that it will be three years before the student is really welcomed into the group. Every effort should be made to break down this barrier so that students feel from the outset that they are beginning to be members of a proud profession.

Emotional Maturity

The group equated emotional maturity with mental health and took as a starting point the following definition:

> Mental health implies an ability to live in harmony with one's environment; to survive, to compete and to discharge one's responsibilities in relation to personal capacities; to get along with people; to acquire skills that are consistent with ability; to obtain satisfactions; to accept and to live with or overcome personal limitations and to accept the consequences of one's behavior.

Dr. Cruickshank in his article on "Mental Health for Nurses[1]," from which the above definition is taken, draws attention to the fact that there are some environments in which a high level of mental health cannot be achieved, for example work situations that do not provide job satisfaction and recognition, that do not encourage participation, that tend to degrade the status of the individual and undermine his feeling of importance. Our hospitals with their traditional authoritarian patterns of organization, their lack of real communication between levels of workers, their somewhat cold, rigid formalism, their tendency to divide workers and students into groups having superior and inferior status, do not provide the most wholesome type of mental environment. Dr. Esther L. Brown in her article "The Social Sciences and Improvement of Patient Care[2]" points up these same deficiencies. It would seem that a concerted effort needs to be made to promote real teamwork among all hospital staff and develop a more permissive and wholesome milieu both for the students and hospital personnel.

Within the general framework of improving the mental environment of the hospital a variety of steps may

be taken to help the student in her emotional growth and in her interpersonal relationships. Formal lectures are secondary in importance to experiences in the clinical situation which might be utilized to give students the opportunity to increase their understanding of themselves and their patients, and to increase their skill in establishing helpful relations with patients. Suggestions for these experiences were:

1. Giving the young student opportunity to interview patients without any actual care being involved so that she will see that patient as a person without being hampered by procedure.

2. Grading patient assignment for the student so that she will be caring for patients suitable to her level and not be bogged down with technical procedures.

3. Sufficient clinical guidance so that the student will have an opportunity to discuss her patients' problems and observations, and her reaction to these, with the instructor and receive help in utilizing the information she has gathered to give more comprehensive care.

4. Having the student keep "logs" of her conversation with the patient and help her to use these to improve her understanding of, and approach to, patients.

5. Utilizing role-playing of student-patient interactions as a teaching tool.

6. More effort on the part of supervisors, head nurses and instructors to recognize and identify psychological factors for the student and help her to understand, accept, and deal with them.

We do not help the student to be "in harmony with her environment" when there is too wide a gap between the classroom situation and the ward, although minor differences may be used to promote adaptability and flexibility. Too great a difference causes conflict in the student producing the discomforts of chronic anxiety. We add to this discomfort by our tendency to teach students to be ritualistic and at times almost compulsive in carrying out their procedures. The nurse becomes upset and frustrated when factors present themselves which prevent the carrying out of these rituals. With this type of pattern the patient does not always receive the highest quality of nursing care since the nurse is satisfying her own artificially induced needs instead of those of the patient. We tend to produce the stereotype nurse because instructors and graduates have been brought up in this system and in their turn become anxious when the student does not adhere to the pattern. As the instructor helps the student to adjust to the needs of the patient instead of always attending to "things," the instructor must be prepared for, and willing to accept her own anxiety if the stereotype behavior pattern is to be broken.

Providing the student with the opportunity to give nursing care through the application of principles rather than rote procedure will help to prevent the formation of ritualistic behavior and promote flexibility and adaptability. Basic to this type of care is the necessity for a patient assignment that is not too heavy but allows time for reflective thinking and planning. The development of these qualities might further be fostered if students were permitted, through group work, to formulate their own procedures from principles.

The student-teacher relationship is one of the most important factors in the development of the elements which contribute to emotional maturity. It is possible for the instructor to insist on standards which protect the safety of the patient and provide for quality care and still maintain a permissive attitude toward the student. A warm, supportive attitude removes from clinical guidance the destructive and distorting elements of "snoopervision" and encourages the student to seek and benefit from help which does not threaten her self-regard. Essential in the development of this relationship is the provision for sufficient instructors to allow time for individual clinical guidance, conferences and educational counselling. When the process of wholesome educational counselling is established by an instructor who shows she has time to devote to the needs and problems of the student we can expect that the student's growth toward emotional maturity will be fostered in other than the purely educational area by her seeking advice and counsel from the instructor in regard to problems and difficulties in her personal life.

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2. Brown, E. L. Social Sciences and Improvement of Patient Care. *Canadian Nurse,* March, 1956, pp. 175-9.

Résumé

LA revision du programme d'études des écoles d'infirmières de l'Ontario a donné l'occasion à un groupe d'infirmières de faire une étude sur ce sujet. Le programme d'études ou curriculum est pris ici dans son sens le plus étendu.

Le sujet à l'étude fut: Comment l'école d'infirmières peut-elle inculquer à l'étudiante des qualités professionnelles? En d'autres termes:

a) Quelles sont les qualités professionelles que l'on se propose de développer chez les étudiantes?
b) Quelles opportunités doit offrir le curriculum pour favoriser le développement de ces qualités? Que faut-il éviter pour ne pas nuire à ce développement?

Les traits caractéristiques suivants sont considérés comme importants dans le développement d'une infirmière professionnelle:

1. *Etre consciente du fait social:* Connaître les agences sociales et participer à leurs activités.
2. *L'esprit de corps:* supporter et participer aux organisations professionnelles.
3. *Maturité émotionnelle:* bonnes relations interpersonnelles, souplesses et adaptation.

Le développement de ces qualités est l'oeuvre non seulement de l'école; les infirmières et les organisations professionnelles y ont aussi leur part de responsabilité.

1. Pour atteindre le premier objectif, il est suggéré que l'étudiante ait le temps de participer à l'activité sociale et que l'infirmière fasse de réels efforts dans le même sens. Le corps professionnel et le groupe des étudiantes devraient être représentés dans les organisations locales de bien-être social, "Local Council of Women," etc.

Les étudiantes devraient être encouragées à continuer de faire partie des Guides, à poursuivre leurs cours de musique, à assister aux diverses conférences, concerts, etc.

L'enseignement de chaque matière devrait continuer à montrer à l'étudiante à évaluer les besoins de chaque personne au point de vue santé et social et comment répondre à ces besoins puis les effets de la maladie aux mêmes points de vue.

2. *Esprit de groupe:* Une association d'étudiante active et démocratique est le premier pas à faire pour habituer les étudiantes à participer aux activités des associations professionnelles. Divers comités devraient être formés: activité sociale, amusements, finance, publicité, etc. Des relations plus étroites devraient exister entre les associations professionnelles et les étudiantes.

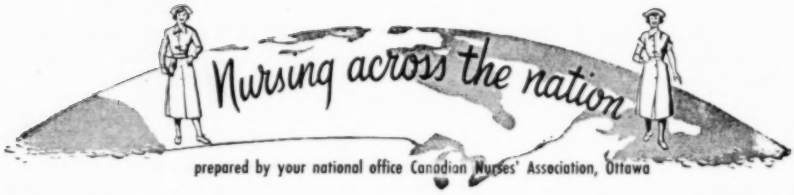
3. *Maturité émotionnelle:* "La santé mentale permet de vivre en harmonie avec son entourage, de survivre, de lutter, de déléguer ses responsabilités, s'accorder avec ses semblables, développer ses aptitudes, être heureux, d'accepter de vivre selon ses moyens et d'être capables d'accepter la conséquence de ses actes."

D'après cette définition du Dr. Cruikshank, nos hôpitaux avec leur organisation traditionnelle autoritaire, le manque de communication entre les diverses catégories du personnel, leur formalisme rigide, froid, ne fournissent pas toujours un milieu favorable à un développement mental idéal.

Des suggestions sont faites pour que l'étudiante s'intéresse autant au malade comme personne humaine qu'aux traitements qu'elle doit lui donner.

Les bonnes relations entre l'étudiante et l'institutrice sont un facteur important dans le développement de la maturité émotionnelle. L'institutrice pour guider son élève doit avoir du temps à sa disposition; cette dernière s'adressera à elle non seulement pour acquérir des connaissances mais aussi pour lui exposer les problèmes de sa vie.

The faculty for myth is innate in the human race. It seizes with avidity upon any incidents, surprising or mysterious, in the career of those who have at all distinguished themselves from their fellows, and invents a legend to which it then attaches a fanatical belief. It is the protest of romance against the commonplace of life. The incidents of the legend become the hero's surest passport to immortality. The ironic philosopher reflects with a smile that Sir Walter Raleigh is more safely enshrined in the memory of mankind because he set his cloak for the Virgin Queen to walk on than because he carried the English name to undiscovered countries. —W. SOMERSET MAUGHAM



Season's Greetings

National Office staff joins in extending greetings to nurses everywhere for a holy and joyful Christmas season. May you all enjoy health, happiness and pleasant family gatherings during this week of festivities.

Nurses and the Royal Visit

Echoes of the magnificent Royal Visit are still being heard around our Capital city. Some of our nursing leaders were presented at two of the impressive events, held during the visit of Her Majesty, the Queen and His Royal Highness, Prince Philip.

The Government of Canada entertained at a reception at the Chateau Laurier. There the President of the Canadian Nurses' Association, **Miss Trenna Hunter**, and **Miss Christine Livingston**, Director-in-chief of the Victorian Order of Nurses for Canada were presented. The excitement and thrill of this reception, as well as all events connected with the Royal Visit, defy the telling. But all who took part or even witnessed the ceremonies from afar will long remember the gracious, charming smile of a lovely sovereign and the friendly easy manner of her consort.

Those who watched the moving wreath-laying ceremony at the National War Memorial on television will probably recall that **Miss Evelyn Pepper** as President of the Nursing Sisters' Association of Canada was presented to Her Majesty who engaged her in conversation. Miss Pepper represented nurses who served in both world wars.

Also at the War Memorial that beautiful October morning was **Lieutenant (M.N.) Margaret Godin** representing the women of the Canadian Forces. Miss Godin, a public health nurse employed with the Ottawa Health Department, is a member of the Royal Canadian Navy (Reserve).

Change of Staff

National Office staff was depleted recently when **Miss Frances McQuarrie**, Nursing Education Secretary and a member of CNA staff for five years, returned to her native province of British Columbia. Miss McQuarrie has joined the staff of the R.N.A.B.C. We in National Office shall miss her. We know that the many Canadian nurses who have met Miss McQuarrie in connection with CNA work join us in wishing her well in her new position.

News of the Pilot Project

The latest contribution to the Pilot Project for the Evaluation of Schools of Nursing comes from the Province of Prince Edward Island. One dollar per member in the Association of Nurses of P.E.I. will be donated to the Project early in 1958. For the President and members of the CNA our grateful thanks to this small province for its generous support.

The Director: **Miss Helen Mussallem**'s experience with the National League for Nursing is rapidly coming to an end. Early in January, Miss Mussallem will return to National Office to commence the Pilot Project. According to word received from her, the opportunity to participate fully in accreditation procedures has been an invaluable experience. The knowledge gained from this experience will prove beneficial in planning an evaluation program for our Canadian schools of nursing.

Readership Survey

Between October 21 and November 8, 241 nurses interviewed 859 readers

of *The Canadian Nurse*, chosen by random sample. This Readership Survey was undertaken by the CNA's Committee on Public Relations in co-operation with the Editor, **Miss Margaret E. Kerr**. The survey was conducted in an effort to obtain an objective report on reader interest in *The Canadian Nurse*.

To the numerous nurses who assisted — the Provincial Public Relations Chairmen, the interviewers and interviewees — may we express our appreciation of this willing help.

When the results have been tabulated and studied by the National Committee on Public Relations, we shall be reporting to you on the findings.

Canadian Council on Nutrition

In the August issue, we reported to you that the General Secretary, **Miss Pearl Stiver** had been appointed to the Canadian Council on Nutrition. On October 7 and 8, the Council met in the Board Room of the Department of National Health and Welfare. Members from the dietetic, medical, teaching and university fields were represented.

Miss Anne Burns who is responsible for informational materials available from the Nutrition Division and who is well known to nurses in many provinces presented the annual report of the Nutrition Division.

Miss Burns referred to the assistance rendered to the provinces in the areas of research and study. Consultant services are given to other divisions of the federal service such as Civil Defence, Civil Service Health, Indian Health Services, Hospital Design Division and others. Extensive assistance is given to nurses in various areas of Canada, by means of courses and institutes. The important part played by nurses, particularly public health nurses, in the teaching of nutrition was emphasized.

One surprising aspect, at least to us in National Office, indicated that infantile scurvy is on the increase in Canada. This is believed to be the result of casualness created by the fortification by Vitamin D, of canned milk. It appears that mothers seem to assume since they need not worry about cod liver oil they may also forget orange juice.

Due to this and the increase of other nutritional problems in Canada, the Nutrition Council passed a resolution urging the need for increased emphasis on nutrition education by all concerned. Among those vitally concerned with this resolution will be the public health nurses of Canada.

National Committee Meetings

Halifax — The Committee on Nursing Service held a full meeting (of all members representing all provinces) November 21 to 23. Under the chairmanship of **Miss Electa MacLennan**, this meeting took place at Dalhousie Public Health Clinic Building. At time of writing (October) it is not possible to give details of this meeting.

Toronto — For the first time, since the new CNA structure was accepted in 1954, the Committee on Legislation and By-Laws will meet as a full committee, January 10 and 11, 1958. **Miss Helen Carpenter** is Chairman of this committee.

50th Anniversary Meeting

Latest announcements on the program for the CNA General Meeting, June 23 — 27, 1958 are that:

Miss Daisy Bridges, Executive Secretary of the I.C.N. has accepted our invitation to present the Keynote Address at the opening session.

A wreath-laying ceremony will be held at the National War Memorial on Sunday afternoon — June 22.

An International Session will be held with speakers from the international nursing field taking part.

Buffet luncheon will be served daily at the Coliseum for the registrants.

What's New From CNA

A.B.C. of I.C.N. — leaflet linking the CNA with the ICN outlining pertinent facts about the International Council of Nurses and listing CNA representatives appointed to international committees.

50th Anniversary Meeting — *Tentative Program* — up to the minute information on program plans for the June 1958 Anniversary Meeting.

Both may be obtained free of charge from the Canadian Nurses' Association, 270 Laurier Avenue W., Ottawa, Canada.

Le Nursing à travers le pays

Nos meilleurs voeux

Le personnel du Secrétariat National offre à toutes les infirmières ses meilleurs voeux pour un Joyeux Noël. Que les fêtes vous apportent santé, bonheur et joyeuses réunions de famille.

Les Infirmières et la Visite Royale

Les échos de la magnificence de la visite royale se font encore entendre dans la capitale. Deux de nos infirmières furent présentées lors de la visite de Sa Majesté la Reine et de Son Altesse Royale le Prince Philip.

Le Gouvernement du Canada a donné une réception au Château Laurier et notre présidente, **Mlle Trenna Hunter** ainsi que **Mlle C. Livingston**, directrice en chef du "Victorian Order of Nurses" du Canada y furent invitées. Cette réception et tous les événements se rapportant à la visite royale furent des moments de joie et d'émotions. Tous ceux qui ont pris part aux cérémonies ou qui en ont été témoins se rappelleront longtemps le sourire charmant de notre Souveraine et l'air si agréable de son consort.

Celles parmi nous qui ont vu à la télévision la reine déposer une couronne de fleurs au monument aux morts auront remarqué que **Mlle E. Pepper** fut, à titre de présidente de l'Association des "Nursing Sisters" du Canada, présentée à sa Majesté qui lui adressa la parole. Mlle Pepper représentait les infirmières qui ont servi durant les deux guerres.

Au monument aux morts, se trouvait aussi le **Lieutenant (M.N.) Marguerite Godin**, représentant les femmes des forces armées. Mlle Godin est une infirmière hygiéniste, employée au Ministère de la Santé à Ottawa; elle est membre de la Marine Royale (réserve).

Départ parmi le personnel

Le personnel du Secrétariat général compte un membre de moins par le départ de **Mlle Frances McQuarrie**, secrétaire du Comité de l'Education qui nous a quitté après cinq ans de service, pour retourner dans sa province natale, la Colombie-Britannique. Mlle McQuarrie fera désormais partie du personnel de l'Association des Infirmières enregistrées de la Colombie-Britannique. Le départ de Mlle McQuarrie se fera sentir. Les infirmières canadiennes qui l'ont connue se joindront certainement à nous pour lui offrir nos meilleurs voeux de succès dans sa nouvelle position.

Nouvelles de l'Etude-essai sur l'accréditation

La dernière contribution reçue en faveur de l'Etude-essai sur l'accréditation, pour l'évaluation des écoles d'infirmières, nous vint de l'Ile du Prince-Edouard. L'Association offrira un dollar par membre au début de 1958. La présidente et les membres de l'A.I.C. remercient cette province pour son généreux effort.

La directrice du Projet d'Accréditation, **Mlle Helen Mussallem**, terminera son stage à la "National League for Nursing" à la fin de cette année. Elle reviendra au Bureau national en janvier pour travailler à la réalisation de ce projet. Dans ses lettres, Mlle Mussallem nous dit que sa participation active à l'accréditation des écoles d'infirmières aux Etats-Unis a été pour elle une expérience d'une immense valeur. Les connaissances qu'elle a acquises lui serviront dans la préparation du programme d'évaluation de nos écoles d'infirmières.

Etude sur la revue: L'Infirmière Canadienne

Du 21 octobre au 8 novembre, 241 infirmières interrogeront 859 abonnées à *l'Infirmière Canadienne*, choisies au hasard. Cette enquête sur la lecture de *l'Infirmière Canadienne* a été entreprise par le Comité des Relations Extérieures de l'A.I.C., en coopération avec **Mlle M. E. Kerr**, rédactrice de la revue. Cette enquête a pour but d'obtenir un rapport objectif sur l'intérêt manifesté par la lecture de *l'Infirmière Canadienne*.

Aux infirmières qui ont assisté les con-

vocatrices des Comités de Relations Extérieures dans leur travail, aux personnes qui ont fait enquête et aux abonnées interrogées, nous adressons nos sincères remerciements pour le travail énorme dont elles se sont bien acquittées. Le Comité des Relations Extérieures vous fera un rapport sur cette enquête lorsque toutes les données auront été compilées.

Le Conseil Canadien de la Nutrition

Dans notre numéro du mois d'août, nous avons rapporté que la secrétaire-générale, **Mlle Pearl Stiver**, avait été nommée membre du Conseil canadien de la Nutrition. Le Conseil s'est réuni les 7 et 8 octobre dans la salle de conférences du Ministère de la Santé Nationale et du Bien-être. Etaient aussi présents: Des médecins, diététistes, professeurs et des délégués d'universités. **Mlle Anne Burns** qui assume la responsabilité des publications pour le Ministère de la Santé Nationale et du Bien-être, bien connue des infirmières dans plusieurs provinces, a présenté le rapport annuel de la division de la nutrition.

Mlle Burns fit rapport de l'assistance donnée aux provinces dans le domaine de la recherche et de l'étude. A l'échelon national des services consultatifs sont donnés à la division de la défense civile, du service de santé du service civil, au ministère des affaires indiennes, à la division des Plans d'Hôpitaux et autres.

L'importance du rôle des infirmières, particulièrement des infirmières hygiénistes dans l'enseignement de la nutrition fut souligné.

Nous avons été bien surprises d'apprendre qu'il y avait une recrudescence de scorbut chez les enfants au Canada. Cela est dû à l'ignorance d'un trop grand nombre de mères qui prennent pour acquis que du fait que dans le lait en conserve l'on a ajouté de la vitamine D, il n'y a pas à s'inquiéter et négligent de donner du jus d'oranges aux enfants.

Ce problème en particulier et d'autres se rapportant à la nutrition ont décidé le Conseil à adopter une résolution soulignant l'urgence d'un enseignement plus intense de la nutrition par toutes les personnes concernées. Cette résolution intéressera toutes les infirmières du Canada.

Réunions des Comités Nationaux

Halifax: Le Comité du Service a tenu une assemblée de toutes ses représentantes provinciales récemment, sous la présidence de **Mlle E. MacLennan**, à l'édifice du "Dalhousie Public Health Clinic." Au moment où nous écrivons ces lignes, il nous est impossible de donner plus de détails.

Toronto: Le Comité de Législation se réunira du 10 au 11 janvier 1958 sous la présidence de **Mlle Helen Carpenter**; Ce sera la première fois que tous les membres siégeront depuis l'adoption de la nouvelle structure en 1954.

50ième Anniversaire

Les dernières nouvelles concernant le programme du Congrès de l'A.I.C. du 23 au 27 juin sont:

Mlle Daisy Bridges, secrétaire du Conseil International des Infirmières a accepté notre invitation; elle présentera une adresse, ce sera un événement important du congrès.

Au monument du Souvenir aux morts des deux guerres, un tribut floral sera déposé dans l'après-midi du 22 juin.

Une séance internationale aura lieu, à laquelle participeront des orateurs ayant occupé des postes en nursing à l'échelon international.

Les congressistes pourront déjeuner au buffet du Coliseum.

Ce que nous offre l'A.I.C.

L'A.B.C. du Conseil International des Infirmières, un feuillet qui montre les liens entre l'Association des Infirmières Canadiennes et le Conseil International des Infirmières et d'autres faits concernant le Conseil International. Le rôle des représentantes de L'Association des Infirmières Canadiennes dans les Comités Internationaux.

50ième anniversaire — Le programme à date, tel que projeté pour le congrès de 1958.

Ces deux feuillets peuvent être obtenus gratuitement en faisant la demande à L'Association des Infirmières Canadiennes, 270 avenue Laurier Ouest, Ottawa, Ont.

Everyone has some skeletons shut up in a closet. They may be broken dreams, abandoned hopes, vain regrets — and few of us can resist the temptation to peep at them occasionally.

But "God gave us memory that we might have roses in December." So why use that gift to perpetuate past bitternesses? The past is a fact, the present is a problem — but the future is a promise.

—Roffe Thompson

Infectious Mononucleosis

ELIZABETH LATURNUS

SOCIAL BACKGROUND

GERRY WAS BORN IN SEPTEMBER, 1955. He was the only child of young, healthy parents. When Gerry was admitted to hospital, it was evident that the normal socio-emotional needs of a child had been well satisfied. He had a loving mother and father who showed much affection and understanding towards the developmental needs of their little son. During the first six to seven months of life an infant needs complete protection and care, and little Gerry was no exception.

The need for belonging was well satisfied in the child, which helped him to feel at home in the hospital. A child wants and needs to feel that he belongs to his family, and also to a group outside of his family. This gives him a sense of security in facing new and strange circumstances in life.

GROWTH AND DEVELOPMENT

Birth may not have been Gerry's real starting point, but it marked the beginning of his life as an independent organism. A child's development is dynamic. The present grows out of the past and is influenced by thoughts of the future, and the individual's concept of himself. The family group has considerable influence.

> It provides the emotional atmosphere into which a baby is born — a most important factor. It has the first opportunity to meet the baby's basic needs and his individual needs. The family begins to mold his personality from the moment the child is born.

For these reasons you cannot study babies or older children apart from their families. The child comes into the world to grow but we must not think of growth as merely getting taller and fatter. It is much more complex than that. For example, nerves, muscles and bones grow into intricate systems, so that the baby can focus his eyes, hold up his head, and eventually walk. All babies go through the same stages and do the same things, but not at the same rate. Gerry could not walk at 11 months, another baby might. Both are "normal." One is no "better" than the other. At that age Gerry had reached certain landmarks of physical development:

a) Sat alone without support.
b) Stood up holding on to the play pen or a chair.
c) Took steps with support.
d) Attempted to creep or make similar movements.
e) Reached for objects.
f) Made sounds that were sometimes recognizable.
g) Showed a beginning appreciation of people.
h) Weighed 16-19 pounds.

Children are naturally very receptive and imitative during their early years. They respond readily to impressions made upon them. Parents, teachers and nurses should recognize that they are contributing much to the future character of youngsters as they consciously or unconsciously influence the atmosphere of daily surroundings.

The first year brings great gains in the child's development in body control and locomotion. At birth he is a helpless, squirming, fumbling bit of humanity. He tries out many movements. Some of them produce desirable results, these he repeats. His rather aimless bodily activity, in turn, stimulates growth. By the end of a year, he has become an individual who can control his environment to some extent. He is ready to explore a wider world. What he lacks in skill, he makes up in effort.

Bringing up a young child is, in fact, helping the child to make the transition from loving only himself to loving others; from pleasing only himself to giving others pleasure, and from recognizing only his needs and their satisfaction to acknowledging those of others. If this is done without destroying his self-confidence and without deforming

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Miss Laturnus carried out this study during her second year at St. Joseph's Hospital, Victoria, B.C.

his personality by giving him feelings of resentment, inferiority, or fear, then his parents have succeeded in starting him on the way to mature adulthood.

Medical Background

Gerry weighed five pounds and eleven ounces at birth. He went down to five pounds and three ounces soon after birth which was to be expected, but from that time until he became ill he had done well. His mother was concerned about the flattening of his head. He tended to lie on the right posterior occipital area with resultant flattening. Gerry was also admitted to hospital with bilateral otitis media. This subsided reasonably quickly.

His Illness

Gerry was admitted to the pediatric department with symptoms of petechial generalized rash, generalized lymphadenopathy and intermittent fever. Three weeks prior to admission, when he had what was thought to be an otitis media, his temperature rose to 103° rectally, on several occasions. He had shown signs of marked irritability, occasional vomiting and constipation. His white blood cell total on one occasion at that time was 3500. It was felt that the condition was probably due to a virus infection.

One week later little Gerry developed a petechial rash over most of his body area. It appeared very irritating and Gerry continued to run an intermittent fever. On admission lymphadenopathy could be found in inguinal areas, the axillary areas and the anterior and posterior cervical areas. He was very pale and irritable. His condition was a puzzling one. There was a presumptive diagnosis of acute leukemia. However, three days after admission, the initial white blood cell count excluded this diagnosis. In view of the history of petechial rash, the febrile course of this illness, the toxicity, the signs of central nervous system irritation, the appearance of generalized lymphadenopathy and the positive Paul-Bunnell agglutination test, a diagnosis of infectious mononucleosis was confirmed. Little Gerry was now desperately ill. He was moved to an isolation unit where all means were taken to surround him with an atmosphere of kindness, coupled with all of the technical devices for his treatment and care.

Definition: Infectious mononucleosis is a generalized infection whose only essential sign is that at one time in its course, there is an increase of mononuclear leukocytes of the blood and glandular fever.

Tests

Immediately following his admission, Gerry underwent various tests and examinations.

Physical examination: The baby was fairly well-developed and well-nourished although pale and irritable as a result of his illness. His skin was covered with a rash that had broken down in some areas — particularly the buttocks — and appeared inflamed. The skull had some slight flattening; the eyes were normal; the mouth healthy. There were enlarged nodes in the postcervical, anterior cervical, axillary and inguinal areas. Lung and heart sounds were normal. Abdominal palpation did not reveal any masses, enlargement of organs or tenderness. Extremities and spine showed normal development.

X-ray of chest: The initial report showed no abnormalities. Repeat examination five days later indicated fluid in the left pleural space.

Hematological examination:

Hemoglobin	10.0 gm./cu.mm.
Red blood cells	3,970,000/cu.mm.
White blood cells	14,700/cu.mm.
Platelets	218,000/cu.mm.

A Paul-Bunnell test proved positive. This is a test for infectious mononucleosis in which agglutination of sheep corpuscles in high dilutions of serum occurs. In

Five days later:		*Normal values*
Hemoglobin	11.9gm./cu.mm.	9-15 gm. — 65-100 per cent
Red blood cells	5,060,000/cu.mm.	5,000,000/cu.mm.
White blood cells	17,500/cu.mm.	12,000/cu.mm.
Neutrophils	38% — showing marked toxic granulation	60-70% of W.B.C.
Bleeding time	4 minutes	3 minutes
Clotting time	5 minutes	1-2 minutes

this instance Gerry's blood serum produced 2 per cent suspension in one liter of 1:112 solution.

Urinalysis — negative.

Spinal fluid — negative.

Signs and Symptoms

The incubation period of infectious mononucleosis is considered to be approximately 11 days.

The onset is insidious or acute, frequently characterized by generalized malaise, fever and sore throat. Gerry was pale, irritable and had an intermittent fever as high as 103°.

Enlargement of the lymph nodes appears either early or late in the course of the disease but usually during the febrile stage. The nodes are not tender and rarely suppurate. They may persist for two weeks to a month.

Although Gerry's spleen was not palpably enlarged, this usually occurs in 50 per cent of cases early in the disease and remains for extended periods.

Gerry had a petechial rash over most of his body that persisted for 7-10 days. Skin rashes are seen in 9-18 per cent of cases and usually last for 3-7 days.

Although Gerry did not exhibit it, jaundice occurs frequently. It may be due to a mild hepatitis or a biliary obstruction.

Occasionally the spinal fluid may show an increase in mononuclear cells and protein content. It has also been noted that the removal of 10-20 cc. of spinal fluid may produce symptomatic relief.

Treatment

Diet: On admission to hospital Gerry received the normal foods that any eleven-months-old child might have. His diet included purees of vegetables and fruits, and ground meat. Four bottle-feedings of milk and water were given in addition. Later as his illness progressed and he was unable to retain food properly, he was given glucose and normal saline in distilled water and small amounts of apple juice. It eventually became necessary to feed the baby by gavage during which time he received five ounces of formula every four hours.

Medications:

1) Mulcin — a dietary supplement that helped to offset the very inadequate diet that Gerry was able to take.

2) Aspirin — an analgesic, antipyretic that helps to reduce fever, relieve headache and neuralgic pain.

3) Penicillin — given prophylactically in this instance against the possibility of infection by gram positive bacteria.

4) Vitamin C — Gerry had shown some signs of a deficiency. It is particularly useful in strengthening capillary walls.

5) Gravol helped to control the nausea and vomiting associated with the condition.

6) Kaopectate with Neomycin and Mycastatin — A formula containing two antibiotic preparations that helped to control the diarrhea Gerry suffered from for approximately six days.

7) Syrup of Phenergan — an antihistaminic preparation helped to relieve the discomfort of the skin rash.

8) Sodium luminal — In the later stages of his illness Gerry began to have convulsive attacks. The sedative action of this preparation helped to control the seizures.

9) Calcium gluconate — Given intravenously this preparation helped to relieve skin itchiness; lessened edema; produced a mild sedative effect.

10) Oxygen — This was administered to relieve respiratory distress brought on by the collection of fluid in the left pleural space and the formation of thick mucus in the bronchial tree.

11) Intravenous therapy and blood transfusion — When retention of food by mouth became impossible, intravenous fluids were substituted. A blood transfusion helped to build up blood volume and hemoglobin concentration.

Nursing Care

There is an important difference between nursing children and nursing adults. When nursing a child, the nurse is caring for a person in whom growth changes are taking place at a rate so much more rapid than is possible in an adult, that the adult seems like static material in comparison. Growth is one of the most pre-eminent characteristics and most vital of all tasks of childhood.

The prevention of crippling habits and personality traits are just as important as the prevention of handicaps due to physical causes. As nurses, it is our

responsibility to take the mother's place while the child is hospitalized. It is important that we recognize and understand the social-emotional needs of a child for the development of sound mental health. A failure to provide for this may be the cause of a serious behavior problem.

During Gerry's acutely ill phase, he was sponged gently with soda bicarbonate and water, in an attempt to soothe his irritating rash. His skin was covered with an angry looking macular eruption, which seemed to sap his strength. He was so miserable and uncomfortable that the nursing care involved provided a challenge for his nurses. His linen was changed frequently. Very little clothing covered him, for he was sensitive to the least amount of pressure on his rash-covered body. A cradle light was placed over him to keep him warm.

In order to be kind, it was necessary to appear to be cruel. Poor little Gerry just could not understand why his hands were restrained. A baby's hands are very important, sensitive instruments in helping him to learn about the world. Gerry enjoyed exploring the world about him but his hands were tied to prevent him from scratching and becoming an easy prey to infection.

Very often during the course of the day, Gerry was picked up and cuddled in order to make him feel loved and secure. This was considered a necessary part of our little patient's nursing care. We derived a great deal of satisfaction in experiencing Gerry's response to our affection. How eagerly he watched as we approached his crib! Despite his illness he displayed a great deal of affection in return.

Whenever his hands were free anything that was around his crib found its destination in the baby's mouth. He was teething, and biting on something hard seemed to relieve the pain caused by the teeth trying to push through the gums. Gerry liked to suck his thumb occasionally. During the first six months of life, occasional thumb-sucking is a method of learning, not a bad habit. It was felt that Gerry received a great deal of consolation from this habit.

Gerry cried very little. When he first came to us, his cries were made more or less mechanically in response to internal sensations of pain, hunger, or satisfaction. The intermittent wail of hunger can usually be distinguished from the sharp crescendo cry of anger; the brief, high-pitched and shrill scream of pain. But as his condition became worse we often wished he would cry once in a while just to show us that he had a bit of energy.

The following procedures were carried out in an effort to keep the baby as comfortable as possible.

1) Gerry was changed from side to side every half hour to prevent pressure sores and stiffness.

2) His temperature, pulse and respirations were taken and recorded at least every two hours to keep a close check as they fluctuated rapidly.

3) Gerry was sponged with tepid water and given Aspirin gr. 2½ to bring down his temperature which at times went as high as 105.4°.

4) Gerry breathed through his mouth in an effort to suck in more air and his lips became very dry and cracked. Oral care was given to keep them moist and to prevent any soreness.

5) The baby was troubled with a large amount of thick mucus that was suctioned out frequently to prevent choking.

6) Gerry passed large, watery, bright yellow stools. He was changed often and special care was given to prevent excoriation of the buttocks.

7) For three days he received nourishment through a series of intravenous injections, then he was gavaged with formula every four hours. The intravenous was administered through a cut-down and had to be watched very carefully. The amount of fluid absorbed was recorded every hour. Only 75 cc. could be absorbed in one hour.

8) The oxygen tent was kept tucked in tightly and the cooling system was checked regularly so as to give Gerry the greatest benefit possible.

It was evident as the days progressed, that little Gerry's life on earth was coming to an end. His death occurred as a result of the combined effects of

1) Infectious mononucleosis

2) Bronchopneumonia with multiple abscesses

3) Empyema — left pleural cavity.

Who has not courage needs legs. —Italian Proverb

Retrolental Fibroplasia

PHILIP BANISTER, M.D.

RETROLENTAL FIBROPLASIA was first described by Terry in 1942 as a result of his observations on premature infants who later became blind. Since then the disease has been seen in almost every country.

It is not easy to determine the number of cases of R.L.F. that have occurred for many mild ones have escaped detection. Until recently the condition was seen mainly in the centres where the care of the premature infant had become specialized. At the moment it is estimated that there are more than 8000 children in the United States blind as a result of retrolental fibroplasia. Some years ago the occurrence of cases in any one centre varied considerably and an estimate of the rate of incidence was not reliable. New cases are still developing due principally to ignorance of the means of preventing the disease. There has been no incidence in this centre for the past three years.

This disease follows a disturbance of the growth of blood vessels in the retina. In a normal, newborn infant the blood vessels have grown almost to the periphery of the retina. In the premature baby, active growth of these vessels is still taking place at birth. In the babies who develop retrolental fibroplasia some agent causes the blood vessels to dilate and to grow in an abnormal direction and manner. Damage to the walls of the capillaries leads to hemorrhage and edema of the retina. During the healing stages scarring occurs with distortion and sometimes detachment of the retina. A mass forms behind the lens. These changes are present in both eyes but they may be of varying degrees. Marked scarring of the retina will cause blindness.

Dr. Banister conducted research studies on this condition at the Royal Victoria Montreal Maternity Hospital.

It has now been shown by animal experimentation and also from the observation of large numbers of babies that the use of excessive amounts of oxygen is the cause of the disease. This association with the use of oxygen was first suspected about six years ago, but it is only in the past three years that it has been confirmed. Once the disease is established no existing method of treatment is likely to have any effect on the final outcome. Earlier reports of the efficacy of hormone therapy or of the use of high oxygen concentrations have not been confirmed.

The disease can be completely prevented by the rigid control of oxygen administration. This is particularly important in babies weighing less than four pounds at birth. No baby should be given routine oxygen. It should be administered only when there are definite indications, for example cyanosis and respiratory distress. Even if there are rapid respirations oxygen should not be used unless there is cyanosis as well.

When oxygen is used it should be given in a closed incubator. The amount of oxygen in the air should be measured with an oxygen analyzer at least every four hours. The oxygen concentration should not rise above 35-40 per cent unless the baby is cyanosed at this level. Oxygen should not be used for more than a few hours except on the physician's orders. He should specify the percentage of oxygen to be used and not the flow rate. The oxygen concentration should be reduced as soon as possible, and administration discontinued when a trial period shows that the baby can do without it. The critical time for oxygen therapy is probably the first ten days of life. If the baby has had high oxygen concentration during this period, then low oxygen concentration later on will not prevent him from developing retrolental fibroplasia.

The villagers of Eastern Pakistan have a peculiar way of cleaning drinking water. The seeds of "strychnos potatorum" are sliced and rubbed round the sides of unglazed earthen vessels in which drinking water is stored. Left for some time, the suspended matter in the water sinks to the bottom. The juice of the seeds acts as a chemical precipitant due to the presence of albumin.

—HAMDARD

Our Premature Darling

MARGUERITE H. L. RICHARD

WE WERE HAPPY BUT SAD, too, for the day had finally come when Debbie was ready to go home. We had grown to love her very much and so it was hard to part with her.

Debbie's mother lost her first baby at three months. For no apparent reason she was having trouble again and was admitted to hospital in labor. Delivery was inevitable so tiny Debbie was born about thirteen weeks ahead of time.

She was placed in the already prepared incubator and watched closely. A wee girl, we were not too hopeful, but with continuous oxygen (4 litres) she breathed easily and had a lusty cry. Four hours later her condition seemed good enough to weigh her — *one pound twelve ounces* was her first weight!

She was given nothing by mouth for twenty-four hours. Her first feeding was five drops of glucose (per dropper), repeated every four hours thereafter in the next twenty-four hours. Her condition remained good and on her third day five drops of Lactogen formula were given. She was voiding regularly. Small amounts of saline were given her rectally and by her fourth day she was having regular bowel movements. On her fifth day she was given two drams of Borden's Sweetened Condensed milk formula (4 tsp. in 16 oz. water). By this time she seemed stronger, moving about in the incubator and crying at intervals. We were truly hopeful that she would survive.

One drop of achromycin was given for prophylactic purposes. Later, vitamins were added to her feedings. This was the daily treatment. As she grew older her formula was increased in amount. Oxygen was given for short periods only, after feedings. When she was receiving an ounce of formula it was decided to gavage her. She sucked vigorously on a medicine dropper but it seemed to tire her.

There was no dehydration and interstitials were not given. In two weeks Debbie's weight was only *one pound 4 ounces*. From then on she started to gain slowly and at nine weeks weighed *three* pounds.

Debbie at twelve weeks, was a big girl! Her weight now was *five pounds one-quarter ounce*. We kept her in hospital as we were giving her an iron preparation intramuscularly. She seemed perfectly normal in every way — she slept and ate well and cried for attention. Her head, of course, showed evidence of her prematurity — that is, flat on the sides — but this condition was improving.

Since premature babies stay in the nursery so much longer and are handled as little as possible in the early weeks after birth, they require all the love and attention the obstetrical staff can give. Debbie was certainly loved by everyone and did thrive on her cuddling.

Most small hospitals have neither the space nor the equipment for separate premature nurseries, so the premature infant must be cared for in the general nursery. Thus Debbie was the star boarder in a busy nursery where most of the other occupants could be termed transients only. With the aid of a carefully regulated incubator, and by available oxygen, tender loving care, and proper formula most premature babies stand a very good chance of survival.

Six years ago, a little two-pound twin won the battle, at this hospital without the aid of an incubator. He did have constant care, oxygen, interstitials and blood transfusions. Today he is living a normal life and is quite the picture of health. We hope the future holds the same prospect for our Debbie.

Miss Richard is Supervisor of the Obstetrical Floor at the Blanchard Memorial Hospital, Kentville, N.S.

A man travels the world over in search of what he needs and returns home to find it.
—GEORGE MOORE

Cirrhosis of the Liver

MARILYN COOPER

PERSONAL HISTORY

ELINOR had been a healthy, normal schoolgirl until shortly after her 16th birthday. She had had the usual childhood diseases without any apparent ill effects. Her family live in a modest home in a small community a few miles from the city. Her father, a laborer, provided well for his family and they lacked nothing in luxury and entertainment at a moderate level.

There were three children in the family — two girls, Elinor and Nancy, and one son, Jimmy the youngest member. The relationship between parents and children appeared good. Elinor stated that any problem could be discussed fully with her parents and a decision made on action to be taken.

Elinor began dating in her 16th year with several boys in her neighborhood. Just before the acute onset of her illness, she began dating steadily with one boy, a classmate at school. She was in her fourth year of high school in the commercial course. Like many teen-agers, her interest in school was declining and she often talked of terminating her education to start working in the city. Living 10 miles from the city, Elinor did not work after school or on weekends due to the expense and time spent in commuting to the city. The jobs available in her own village were limited.

Elinor was a shy girl, rather pretty, dark, and of medium height. Once beyond the first introduction she quickly overcame her shyness, but still tended to be slightly introverted. She had a great range of interests including all types of sports, extracurricular activities at school, movies and church activities. She was a regular member of her Sunday School and church, and of the groups of young people in the church.

ETIOLOGY

Terminal cirrhosis of the liver occurs mainly in middle age and is most common in males. One contributing factor is alcoholism, but it may result from chronic metallic poisoning or from infectious diseases. It is a symptom of Banti's disease as well. There is considerable evidence to indicate that the fundamental cause of this condition is a deficiency in some dietary factor, probably a protein constituent.

It is characterized by episodes of necrosis involving the liver cells. The destroyed liver cells are replaced by scar tissue which gradually exceeds the volume of the functioning liver cells. The liver is often enlarged in the early stages, but as the scar tissue contracts it becomes smaller. Islands of normal cell tissue are caused by the contraction of the scar tissue thus giving the typical cirrhotic or hobnail appearance to the liver.

The disease is insidious. There is often a long period of development before symptoms are noticed and a diagnosis is made. The course of the disease is long, frequently lasting over a period of several years.

SIGNS AND SYMPTOMS

Early symptoms that may be overlooked are anorexia, nausea, occasional vomiting and fever. Intermittent jaundice, discomfort after eating and constipation may be noticed. These symptoms may disappear for a few years or may occur frequently, gradually becoming worse.

The later symptoms are due partly to the chronic failure of the liver function and partly to obstruction of the portal circulation. There is gradual weight loss. The spleen becomes congested. Abdominal ascites occurs from accumulation of fluid in the peritoneal cavity. As pressure in the portal system increases the collateral veins enlarge. The superficial abdominal veins may become prominent and hemor-

Miss Cooper was a senior student at the General Hospital, Sarnia, when this study was done.

Nurse...

you know that when a Flu Virus hits a hospital, its spread is rapid and relentless. *Disinfection* of patient rooms and public areas is *positive action* the hospital should take to *control* the spread of infection.

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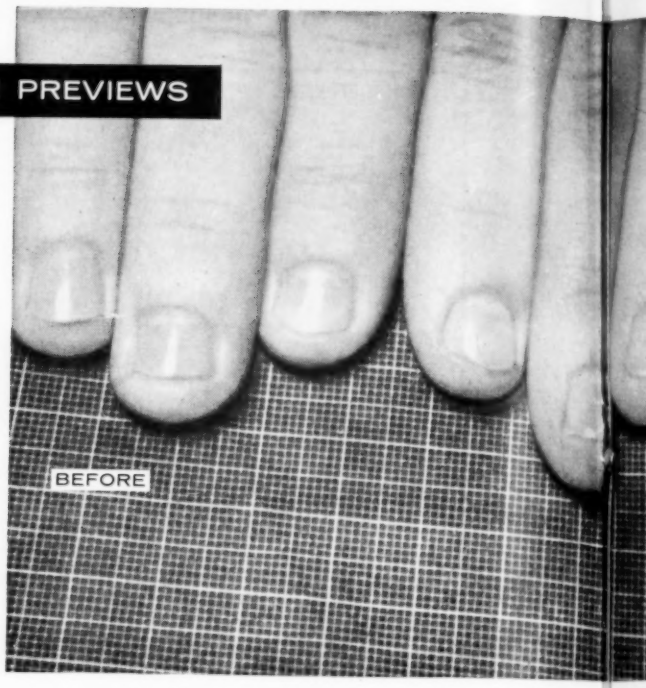

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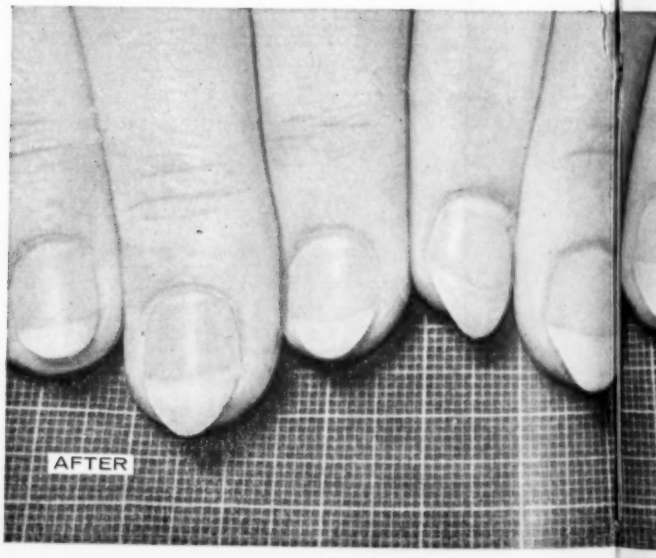

© 1953 Knox Gelatine Co.

Evidence continues to accumulate verifying the effectiveness of Gelatine in the treatment of brittle fingernails. Investigators report that the nails show objective evidence of improvement.[1,2,3,4] Furthermore, patients often volunteer that their nails "feel stronger," "look smoother," and "I can pick up things without them hurting."[1] Evidently the subjective sensations associated with improvement are nearly as important to some patients as the positive physical change in the nails' appearance.

Improvement Noted in 81% of Patients

See the chart below for a summary of the effect of Knox Gelatine in brittle fingernails as observed in all published reports. Photographic evidence of improvement, much of it in color taken before and during treatment, is available for most of the patients.[1,2,3] Please note, however, that where Gelatine was used in the treatment of pathological conditions associated with brittle fingernails only in psoriasis did the data show definite improvement.[1,3,4]

Response to Gelatine in Brittle Fingernails

References	Dosage	Duration of treatment	No. patients w/ brittle nails	No. patients improved	No. patients w/ brittle nails and other pathology	No. patients improved
1. Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: *A.M.A. Arch. Dermat.* 76:330, (September) 1957	7 Gm./day	3 months	**50**	**43** (86%)	**32**[a]	**9**
2. Schwimmer, M. and Mulinos, M.G.: *Antibiot. Med. & Clin. Therapy* 4:403, (July) 1957	7.5 Gm./day	11-16 weeks	**18**	**15** (83%)		
3. Rosenberg, S. and Oster, K. A.: *Conn. State Med. J.* 19:171, (March) 1955	7 to 21 Gm./day	15 weeks	**36**	**26**[b] (72%)		
4. Tyson, T. L.: *J. Invest. Dermat.* 14:323, (May) 1950	7 Gm./day	13 weeks	**12**	**10**[c] (83%)		
Totals	7-21 Gm.	11-16 weeks	**116**	**94** (81%)	**32**	**9** (28%)

a. Gelatine improved psoriatic nails in 5 out of 12 cases. In onychomycosis and other pathological conditions of the nail it was of no appreciable help.

b. Of the failures, 2 had congenital disease of the nails, 3 were diabetics and 3 took the medication for less than one month.

c. One patient with psoriasis and arthritis and one patient with psoriasiform nail changes showed improvement in 2 and 3 months respectively.

BRITTLE FINGERNAILS

Important Note

The pharmacodynamic effects of Gelatine are manifested through its high Specific Dynamic Action, and therefore, depend upon adequate and prolonged intake. All published clinical research has been conducted using 7 to 21 grams (1-3 envelopes) of Knox Gelatine per day for the three to four months that are required for complete regrowth of the nails. Smaller dosage would induce a lesser specific dynamic action and thus prove ineffectual in correcting the brittle nail defects. More detailed information on brittle fingernails and reprints of the two more recent clinical reports are available on request. Please use the attached coupon.

Knox Gelatine (Canada) Limited
Professional Service Department CD-35
140 St. Paul St. West, Montreal, Quebec

Please send reprints of the following articles:

☐ Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: *A.M.A. Arch. Dermat.* 76:330, (Sept.) 1957.

☐ Schwimmer, M. and Mulinos, M.G.: *Antibiot. Med. & Clin. Therapy* 4:403, (July) 1957.

YOUR NAME AND ADDRESS

rhoids develop. There may be small bouts of hematemesis or profuse hemorrhages. The concentration of plasma albumin is lowered, predisposing to edema of the extremities. There is inadequate formation, utilization and storage of vitamins A, C and K. The skin soon looses its natural tint and becomes a muddy color, with possible jaundice which occurs in approximately 25 per cent of the cases.

Late symptoms of the disease are acute forms of those previously mentioned, with delirium, stupor and eventual coma followed by death. Complications that may arise affect the kidneys, heart and blood vessels. These organs are affected by the portal obstruction with back pressure of blood in the cardiovascular system. Tuberculosis of the peritoneum or the lungs is a common complication caused by the generalized lowered resistance to infection.

History of Present Illness

At 16, Elinor was a healthy normal girl to all appearances. Onset of menses and her menstrual periods had been normal up to this time. She began to show irregularity with scanty menstrual flow. Hormone therapy was tried with some success. The sclera of her eyes had had an icteric tint periodically over a period of two years. However this was noted only by the patient and went unnoticed by her parents and her doctor.

It was noted on admission to hospital that she had generalized edema of her legs, abdomen, back and face. Her eyes had a definite yellowish tint. These symptoms had gradually become more prominent. There were no urinary symptoms or dysfunction. Elinor felt perfectly well with no discomfort or complaints.

She was admitted to the hospital for investigation. She was 18 years old at that time. Her only complaint was a feeling of discomfort under her diaphragm with slight shortness of breath. A medical consultant examined her. His report showed blood pressure normal, heart, breasts and thyroid normal and not enlarged. Her abdomen was distended and tense. A shifting fullness could be felt and a fluid thrill. The liver edges and spleen could not be found on palpation. Her lungs had impaired percussion at both bases.

A miniature chest X-ray showed a sharply elevated diaphragm. A complete blood count revealed some changes — in particular an elevated icteric index and blood urea. Liver function tests showed a high thymol turbidity and an increase in bilirubin, urobilinogen and zinc sulfate buffer. A flat plate X-ray of her abdomen revealed a generalized grayness overlying the entire abdomen obscuring the details of soft tissue and bone elements. This was suggestive of peritoneal irritation and probable fluid formation within the abdomen. A stool specimen was negative for occult blood and stercobilinogen content was 150 mg/100 gm. (normal 40 to 280/100 gm.) The red cell fragility test was done. Elinor's rating was 0.6% (normal 0.9 to 0.8%.) The Widal test and Xenopus test were both negative.

Two days after admission, her abdomen was further distended and hard. Vitamin K (Synkavite) was given because of her raised prothrombin time. The patient complained of moderate shortness of breath on exertion. Her skin was now noticeably jaundiced. An abdominal paracentesis was done under local anesthetic and 180 ounces of ascitic fluid were obtained. Microscopic examination of the spun ascitic fluid showed numerous endothelial cells and an occasional round cell. There were no clusters of typically malignant cells. A smear of the fluid was negative for tuberculosis and other organisms. The patient rested quite comfortably after the paracentesis but three days later it was noticed that her abdomen was again becoming distended. Surgery was decided upon in the form of an exploratory laparotomy. Prior to this 1500 cc. of plasma were given to replace that lost due to edema.

A biopsy of the liver was taken during surgery and the portal vein pressure measured. The liver was noted to have the typical hobnail appearance. The portal vein pressure was elevated suggesting obstruction. A rubber drain was inserted through a stab wound to aid in draining ascitic fluid and reducing pressure on the abdominal viscera. A transfusion of 500 cc. of whole blood was given to replace that lost during surgery. The laboratory report of the liver biopsy showed its appear-

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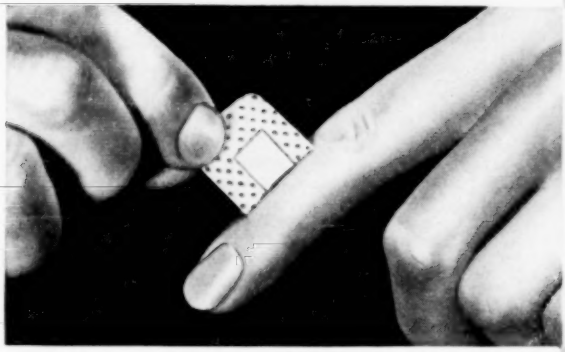

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The pad stretches with the plastic material.

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Elastoplast 'Airstrip' First Aid outfit containing 120 dressings of assorted sizes (Order No. 7957).

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ance to be consistent with advanced cirrhosis. There was no evidence of malignancy.

Nursing Care

On admission to a hospital the patient meets many strange sights. What seems routine to a nurse, such as chest X-ray and urinalysis, is a different matter to a new patient. To explain procedures and maintain the confidence of the patient in her doctor, falls within the duties of the nurse. She must make the patient comfortable and acquaint her with her new surroundings.

Elinor did not appear acutely ill. She was ordered complete bed rest except for bathroom privileges. She was a cheerful girl and did not believe her illness to be of a severe nature. She adjusted to hospital routine quickly and easily. Before her surgery, Elinor was very cooperative in all treatments and tests carried out. She did not seem alarmed at any of the different procedures.

On the day of operation a routine catheterization was done and the catheter was left in place. Foods and fluids had been restricted from 10 P.M. the evening before. A pre-operative sedative was given and the patient was taken to the operating room where, under a general anesthetic, the laparotomy was performed. To relieve postoperative pain, analgesics were given after the patient returned from the recovery room.

The three cardinal factors in treatment of cirrhosis are bed rest, proper diet and avoidance of anything that might be injurious to the liver. Visitors should be restricted to the family only, to avoid overtiring the patient.

With the resulting liver insufficiency, due to its contracted state, there may be a tendency to retain sodium. Therefore, there should be moderate restriction of salt. A low fat diet is given because fats are poorly tolerated, often causing nausea and anorexia. Small frequent meals are served to aid in overcoming the anorexia. The patient is catered to, to aid in stimulating her appetite and increasing her food intake. Gravol is given to reduce nausea.

The same day after her operation Elinor's face was swollen and edematous, her color poor. She was depressed, lacked initiative and appeared confused. Her general condition was only fair. She was kept flat in bed. There is some evidence to the fact that an upright position causes increased demands on the liver, therefore a supine position is advisable. Due to her confusion, precautions were taken against possible injury to herself by leaving the bed sides up and frequent observation to note her condition.

Routine postoperative care was carried out. Operative procedures of the upper abdomen are often followed by restriction of respiratory movement. Extra efforts were made to turn the patient often and to encourage her to take deep breaths and to cough. Frequent turning aids in keeping the lungs expanded and also aids in stimulating peristalsis thus controlling distention which often occurs.

Vitamin K was administered as it is essential to the production of prothrombin — a vital factor in the coagulation of blood. The abdominal dressings over the incision and drain were watched carefully for signs of hemorrhage. When these dressings were first changed a large amount of serous drainage was present. Fluids were forced during the first few days. An accurate chart of the intake of fluids and output of urine was kept.

To overcome Elinor's apparent depression, attempts to keep her interested in quiet diversions were made. Encouragement and praise were given for small gains and achievements. The abdominal drain was removed five days after surgery, and the sutures two days later.

Personal hygiene was cared for during the early morning bath and before meals. The patient was encouraged to help herself. About 10 days after surgery, her confused state had completely disappeared and her depression lessened. She became interested in her surroundings again and her appetite improved. She was up and around more during the day.

Previous to her discharge, Elinor was taught to change her own abdominal dressings over the wound that was the site of the rubber drain. There was still considerable drainage. Her condition slowly improved, and 13

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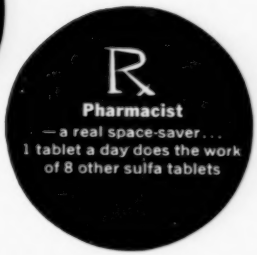

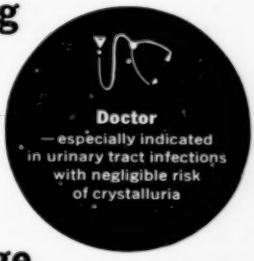

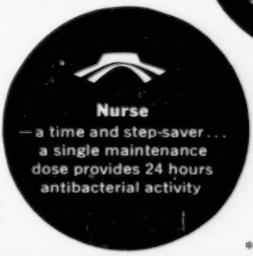

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days after surgery she was discharged to her home for further care and convalescence. On the day of her discharge, she was cheerful but she was still weak and tired easily on exertion. She was informed by her doctor of the necessity to rest during the day. He also warned her that the period of her convalescence would be long and her return to strength slow. Throughout her illness the nature of her condition was withheld from Elinor.

Summary of Therapy Used

1. *Diet* — A low fat, high carbohydrate diet with bland foods that could be easily digested. The food was selected from the patient's likes and dislikes and attractively served, thus helping to stimulate her appetite and improve her general nutritional condition. Small amounts were served at meal time and an afternoon and evening snack given. Eggnogs were served to aid in increasing her protein intake.

2. *Vitamin K* (Synkavite) — Essential to the process of coagulation of blood. Deficiency results in low prothrombin content of the blood, thus leading to marked prolongation of coagulation in case of hemorrhage. Elinor's prothrombin time was elevated and vitamin K helped to correct this.

3. *Seconal* — A sedative was used at night to ensure a good night's sleep.

4. *Morphine sulphate* — An analgesic used in the relief of severe pain. Elinor received this postoperatively.

5. *Aspirin phenacetin compound and codeine, gr. ½* — An aid in relief of pain by oral administration.

6. *Demerol* — An analgesic and narcotic used as an analgesic in the relief of pain and often used as a preoperative sedative. Elinor received this prior to going to the operating room.

7. *Atropine* — Used preoperatively to check secretions in readiness for a general anesthetic.

8. *Gravol* — Reduced the nausea that tends to be a symptom of this condition.

9. *Plasma* — Has almost all of the properties of blood except the ability to carry oxygen. It is relatively free of reactions and allergic manifestations. The concentration of plasma in her body was lowered with the formation of edema and was therefore replaced.

10. *Occupational therapy* is proving very popular in nursing care. It is used physiologically for rest inducing relaxation and reducing tensions and anxiety. Psychologically it helps to overcome fear and anxiety of the possible eventual outcome of the illness and to combat disorientation and confusion by the reality of the objects handled. The value of occupational therapy was impressed on Elinor's mother so that she could help her daughter to keep busy when at home.

For three weeks after her return home Elinor showed no great improvement. She gradually lost strength and her condition grew worse. She remained at home however with her mother and sister caring for her. She died four weeks after her discharge from the hospital.

The liver is a large and vital organ in the body. When disease affects the liver, surgical treatment is of no success. The outlook for cure is unfavorable. While the course of the disease often extends over many years after the occurence of ascites. Death usually results from exhaustion, hemorrhage, pulmonary edema, intercurrent infection or toxemia. Once discovered the course of the disease in this instance was shift. Her progress from discharge until her death was marked by a slow decline of physical strength and a gradual realization on her part that her condition would not improve.

Six Rules to Remember Names

1. Whenever you hear a name, repeat it to yourself — immediately.

2. Use the name at least twice when speaking to the person. When you take leave of him, say his name once more.

3. Each time you use the name, take a candid mental snapshot of his face.

4. When you see him again, say his name.

5. At night, write down the names of all the people you met during the day, noting their dress, subject of conversation, and so forth. Then associate each name with a mental picture of the person.

6. Make a business of collecting new names and faces and of associating the right name with the right face.

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Sélection

La Colibacillose

L'INFECTION URINAIRE provoquée par le colibacille ne doit en aucun cas être négligée, car, si elle réagit admirablement aux traitements modernes par les antibiotiques, elle n'est cependant pas à l'abri des rechutes, qui sont le plus souvent en rapport avec un obstacle gênant: l'évacuation de l'urine responsable de la stase urinaire et de la pullulation des colibacilles.

Sans méconnaître le côté intestinal de la maladie, il est de fait que le terme "colibacillose" désigne essentiellement l'infection urinaire à colibacilles: il serait donc bien préférable de parler de "colibacillurie" plutôt que de "colibacillose" terme imprécis malheureusement consacré par l'usage.

Le diagnostic de la colibacillurie est évident lorsque le tableau clinique est celui de la *pyélonéphrite aiguë*, qui est en réalité une pyélite simple sans atteinte du parenchyme rénal: la fièvre élevée, les douleurs lombaires uni- ou bilatérales, les urines troubles suffisent pour faire évoquer d'emblée l'infection urinaire qui sera vite confirmée par l'examen cyto-bactériologique des urines montrant la présence d'une pyurie à colibacilles.

Restent encore à signaler les *pyélonéphrites de la grossesse* dont le colibacille est le germe causal dans 90% des cas. Favorisée par l'atonie et la dilatation des voies urinaires à l'origine d'une stase urinaire, l'infection urinaire se localise le plus souvent du côté droit et apparait surtout dans la deuxième moitié de la grossesse. Elle revêt aussi bien le tableau clinique de la forme la plus discrète que celui d'une forme grave. Souvent rebelle au traitement ou récidivant pendant la grossesse, elle disparait en règle rapidement après l'accouchement.

L'apparition des antibiotiques a considérablement modifié l'évolution de la colibacillose puisque cette thérapeutique permet en bien des cas de mettre fin en quelques jours à l'infection colibacillaire même la plus virulente. Cependant les antibiotiques ne résolvent pas tous les problèmes et il existe encore des colibacilloses chroniques et récidivantes; ceci tient à ce que l'action des antibiotiques n'est que temporaire et ne permet pas d'espérer un résultat durable si la colibacillose est entretenue par une cause urologique ou intestinale. Les traitements étiologiques gardent donc toutes leurs indications et ne sauraient être rejetés au second plan.

L'administration d'antibiotiques s'applique à tous les cas de colibacillose, mais alors qu'un tel traitement suffit en général dans la plupart des formes aiguës, il demande à être associé aux traitements étiologiques dans les formes atténuées, volontiers chroniques ou récidivantes.

Dans l'ensemble, les sulfamides possèdent une remarquable activité vis-à-vis de la colibacillose, mais il faut signaler que la médication sulfamidée peut perdre peu à peu son efficacité et qu'il peut se développer une sulfamido-résistance.

L'apparition des antibiotiques fungiques a constitué un nouveau progrès dans le traitement de la colibacillose; la mycothérapie permet en effet de venir à bout de certaines formes rebelles, soit par sulfamido-résistance de certaines souches de colibacilles, soit surtout par suite de l'association fréquente aux colibacilles de germes résistant aux sulfamides. Elle constitue enfin une indication majeure lorsque le malade se montre intolérant aux sulfamides, ce qui n'est pas exceptionnel.

Devant une telle gamme de médications antibiotiques, l'embarras du choix peut être grand. C'est pourquoi il est nécessaire d'adapter le traitement à la gravité de la forme observée, tout en sachant que le colibacille est un germe très vulnérable qui ne résiste pas habituellement aux sulfamides et aux divers antibiotiques fungiques. Reste cependant le cas des colibacilluries rebelles et récidivantes qui posent un problème thérapeutique particulièrement délicat: l'étude de la résistance du germe in vitro est alors souvent d'un certain secours, malgré les réserves qu'on doit formuler sur cet examen; la répétition des examens cyto-bactériologiques des urines est également nécessaire car il n'est pas rare de voir se développer d'autres germes au cours de l'évolution de la maladie: l'association d'antibiotiques présente alors un réel intérêt pour obtenir une meilleure efficacité à des doses moins élevées de chacun d'entre d'eux.

Ces diverses notions permettent de donner aux traitements antibiotiques une remarquable efficacité, suffisante pour amener dans bien des cas une guérison complète et dura-

In contrast to proprietary formulas, which can only be made weaker or stronger, the evaporated milk formula is *flexible* because it can be:

– adjusted in dilution and *carbohydrate* to meet neonatal needs without renal overload.

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ble: elles ne doivent pas pourtant faire oublier la nécessité fréquente d'associer les traitements étiologiques.

Ces nouveaux traitements n'ont cependant pas complètement résolu tout le problème thérapeutique, puisqu'il reste à traiter le pôle intestinal et le pôle urinaire de l'affection, seuls traitements susceptibles d'éviter les récidives.

D. Fritel est Médecin-Assistant des Hôpitaux de Paris. *Revue de L'Infirmière.*

In The Good Old Days

(The Canadian Nurse — DECEMBER, 1917*)*

A new feeding system has been inaugurated in one of the hospitals in Paris. Carts, which carry a pan of coals under sliding drawers containing food, are wheeled from ward to ward and the food deposited. It is kept piping hot and much time is saved.

* * *

In the various researches in diseases of children of today, no group of abnormal conditions has received such intensive study as rachitis, scurvy, tetany, osteogenesis-imperfecta, infantile beri-beri and pellagra.

* * *

An army nursing sister described her visit to Compiegnes, France, in order to observe the Carrel Treatment for wounds, which was then becoming very popular. The preparation that was used for the sterilization of wounds was Dakin solution.

* * *

This is the fourth Christmas since the war began. Just as this number goes to press the news of the frightful disaster at Halifax reaches us. To all of us the call goes up for help in every shape and surely the nurses will be among the first to give of their service, money and supplies.

* * *

Bakers' yeast has been found a useful remedy in the treatment of furunculosis, acne, constipation and other cutaneous and gastrointestinal conditions.

Book Review

The Yearbook of Modern Nursing — 1956. Edited by M. Cordelia Cowan. Foreword by Mary M. Roberts. 446 pages. G. P. Putnam's Sons, New York.

Reviewed by Miss Helen Mussallem, formerly Associate Director of Nursing Education, General Hospital, Vancouver, B.C.

A nurse would have to devote her full time to reading if she wished to keep up with all the literature of value to nursing. Fortunately, we may now turn to one volume for a survey of major developments in nursing during the past year.

In this book, original articles and opinions of 169 collaborators have been organized into 23 sections. Some of these sections are "The Art of Nursing," "The Scientific Basis of Nursing," "In-Service Education," "Films and Film Strips," "Research in Nursing." Annotated bibliographies, digests, reference lists, charts and graphs add to the rich supply of original material. These are all carefully cross-indexed to make the material readily available.

Although much of the material is related to nursing in the United States, an attempt is made to broaden its scope by including articles from other countries. But if this book is to be truly a yearbook of modern nursing more than three of the collaborators should be from outside the United States. Of particular interest to Canadian nurses is the "Summary of Development in Nursing in Canada."

Many unusual features make this book a valuable tool. Of particular note is the table of "Newer Drugs and Drugs with Newer Uses." This book is highly recommended for nurses, who, because of time limitations, find it impossible to survey even casually the current nursing literature.

If you ever live in a country run by a committee, be on the committee. —W. G. SUMNER

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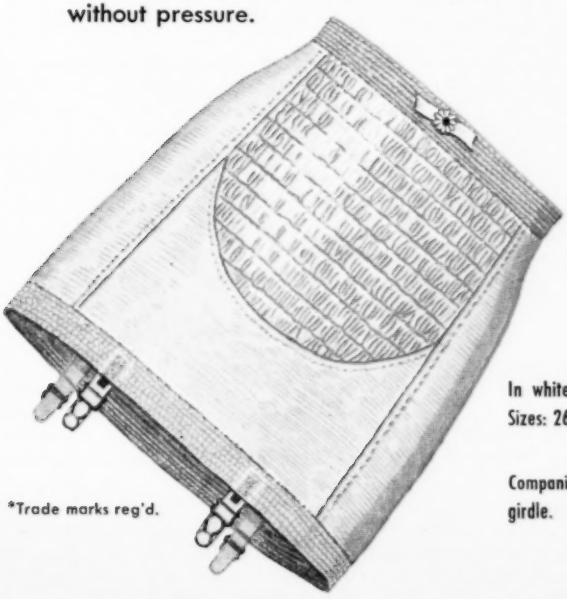

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British Columbia

THE FOLLOWING ARE the staff changes that have taken place in the Public Health Nursing section of the Metropolitan Health Committee, Vancouver.

Appointments — Mrs. *Frances Barnes*, Mrs. *Alberta Boyd*, *Sharon Burwash*, *Edith Christie*, *Joan Crawford*, *Norma Dady*, *Diane Darbey*, *Veda Dickinson*, *Elizabeth Donald*, *Dorothy Farmer*, *A. Gibson*, Mrs. *Ann Gibson*, *Marilyn Gowan*, *Edith Hodgson*, *Patricia Holmes*, Mrs. *J. Hutton-Potts*, *Elduned Jenkins*, *Jacqueline Julian*, Mrs. *Elizabeth McGregor*, *Marjorie McLaughlin*, *Audrey Moody*, *M. Morrish*, *Anne Morrow*, *Phyllis Palmer*, *Kazuke Takahashi*, *Sheila Twentyman*. To staff positions.

Supervisory appointments — *Margaret Briggs* (Univ. of Toronto) as acting assistant supervisor in Health Unit three; Mrs. *Bernice Hatcher* (U.B.C.) as acting assistant supervisor in H.U. two; *Lucille Giovando* (U.B.C., Univ. of Minnesota) as assistant supervisor in the North Shore Health Unit; *Beverly Wilson* (U.B.C.) as supervisor in the Richmond H.U.

Leave of absence — M. *Parrett* has been awarded a Federal training grant and is enrolled at the University of Toronto for study in supervision and administration.

Resignations — Mrs. *M. Donavan*, *Lily Dong*, *V. Freeman*, *H. Gray*, *J. Greene*, Mrs. *C. Huene*, Mrs. *B. Hutchings*, *Phyllis Jones*, Mrs. *D. Liggett*, *M. Long*, *G. McIntyre*, Mrs. *B. Mead*, Mrs. *B. Robertson*, Mrs. *C. Sinclair*, Mrs. *B. Sussel*, *M. Thiessen*, Mrs. *B. Wadman*.

Ontario

The following is a list of the staff changes in the Ontario Public Health Services.

Appointments — Mrs. *Eleanor B. (Fendley) McComb*, (Saskatoon City Hosp., Univ. of West. Ont.) to Bertie Township Board of Health. *Mary Esther Highstead*, (Victoria Hosp., London, Univ. of West. Ont.) to Middlesex Co. School Health Service. *Marlene M. Longworth*, (Brantford Gen. Hosp., Univ. of West. Ont.) to Oxford Health Unit. Mrs. *Elizabeth (Williams) Hyland*, (Hamilton Gen. Hosp., Univ. of West. Ont.) formerly with Elgin-St. Thomas H. U., to Peel Co. H. U. *Doris E. Brown*, (Toronto Gen. Hosp., Univ. of Toronto) to Scarborough B. H. *Joyce Nevitt*, (Fulham Hosp., Hammersmith, London, Eng., U. of T.) to Tarentorus B. H. *Betty Coney*, (Misericordia Gen. Hosp., Winnipeg, U. of T.) formerly with Huron Co. H. U. to Waterloo Co. School Health Service. *Ethel E. Hounslow*, (Brantford Gen. Hosp., U. of T.) to Wentworth Co. H. U.

Resignations — *Jean Rowe*, Mrs. *Frances (Taylor) Jamieson* and *Esther V. Matheson*, all from Halton Co. H. U. *Lillian G. Barr* from Huron Co. H. U. *Joan M. Cormack* from Haliburton Co. School Health Service. Mrs. *Myra E. M. (Walker) Chalmers* from Simcoe Co. H. U.

You cannot educate a man wholly out of the superstitious fears which are implanted in his imagination, no matter how utterly his reason may reject them.

—OLIVER WENDELL HOLMES

Victorian Order of Nurses

The following is the list of staff changes for the Victorian Order of Nurses for Canada.

Appointments — Mrs. *Maureen Anderson* (St. Jos. Hosp., Hamilton) to Sault Ste. Marie. *Alphena Dumais* (Hotel Dieu Hosp., Edmundston) to Edmundston. *Mary Glos* and *Maisie Humphries* both (McMaster Univ.) to Windsor. *Marion Gracey* (Toronto Gen. Hosp.), *Marguerite Graham* (Univ. of Toronto) and Mrs. *Jessie Woelfe* (McMaster Univ.) to Toronto. Mrs. *Dorothy Hall* (Toronto Gen. Hosp.) to Sarnia. *Winifred Hooser* (Saint John Gen. Hosp., N.B.) to Fredericton. *Annette Lalonde* (Ottawa Univ.) to Oshawa. *Bernice Lomas* (Misericordia Hosp., Edmonton) to Edmonton. *Lillian Paslowski* (Winnipeg Gen. Hosp.,) to Winnipeg. Mrs. *Joy Rustige* (Saint John Gen. Hosp.) to Saint John. Mrs. *Laura Selves* (Stratford Gen. Hosp.) to Woodstock, Ont. *Ethel Shaw* (Hosp. for Sick Children, Toronto) to Montreal. Mrs. *Verna Lou Smith* (Winnipeg Gen. Hosp.)

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to Waterloo. *Joan Van Nest* (Univ. of Toronto) to Vancouver. *Frances Ward* (St. Jos. Hosp., London) to Regina.

Transfers — *Monique Allard* to Montreal, *Sheila Devlin* to Medicine Hat. *Joan Dubs* to Windsor. *Margaret Holder* to Moncton. *Frances Lee* to Corner Brook. *Janet Ramage* to North Bay.

News Notes

ALBERTA

District 3

Calgary

Holy Cross Hospital

Approximately 500 graduates attended the festivities in connection with the 50th anniversary of the school of nursing which occurred early in October. An anniversary mass, held in St. Mary's Hall, was followed by registration of the guests. Mrs. J. W. Wilson and J. Cummins convened a buffet luncheon held in the new nurses' residence. The guests were received by Sr. Superior Claire Gauthier and Sr. Cecile Leclerc, director of nurses, assisted by Mrs. W. J. MacDonald president of the alumnae association, and Mrs. A. M. S. Brown, general convenor of anniversary arrangements.

A reunion banquet, convened by Mmes. L. Buchanan, E. Wight and W. McAdam, was held at the Palliser Hotel. Under the capable direction of F. Tennant a colorful program followed the dinner. Graduates of the class of 1910 were specially honored — Mrs. E. (Black) McQuade, Mrs. A. (Martin) Maguire, Mrs. M. (Berg) Fletcher being present for the banquet. A life membership pin was presented to Miss Mona Sparrow in recognition of her work in the nursing profession and the alumnae association. Beautiful scenic pictures were presented from the Edmonton and Vancouver branches of the alumnae. A tour of the hospital and the new nurses' residence and a delightful tea given by the Sisters of Charity completed the anniversary activities.

District 7

Edmonton

General Hospital

R. Bienvenue, science instructor, attended the meeting of the Catholic Hospital Association which was held in Calgary recently. Alice Jean, a student nurse, has been chosen to receive the scholarship offered by the Dale Carnegie Fund. A plan for affiliation with the Mental Institute provides a rotation for six students every two months.

Grande Prairie

Chapters members have undertaken a new series of fund-raising projects with a new oxygen tent for the hospital as their objective. A sale of home baking was held early in October and a cash ticket raffle is a feature of each regular meeting. A committee has been formed to look into the possibilities of teaching the home nursing course sponsored by the St. John's Ambulance. Five members have volunteered to help with the blood donor clinic. Miss I. Morrell who recently accepted the position of matron of the hospital was welcomed to the chapter membership.

BRITISH COLUMBIA

Vancouver

St. Paul's Hospital

Congratulations are extended to Isabel (Clarke) Browning who has won distinction as an artist with her painting "Rocks and Trees." Betty (Wallner) Dybhaon visited briefly. A bazaar will be held early in December and plans are already underway for a dinner dance to be held at the Canyon Gardens early in April.

MANITOBA

District 2

Brandon

General Hospital

Thirty-five members of the alumnae association met recently in the nurses' residence. Committee reports showed that a great deal of good work has already been done by this new organization. Mrs. A. Leitch received a special vote of thanks for her work in preparing the alumnae float for the Traveller's Parade. A reunion of graduates held earlier in the year was very successful — 275 attended and numerous class reunions and dinners were held in connection with it. Dr. J. A. Finlay was the guest speaker on this occasion with gynecology as his subject.

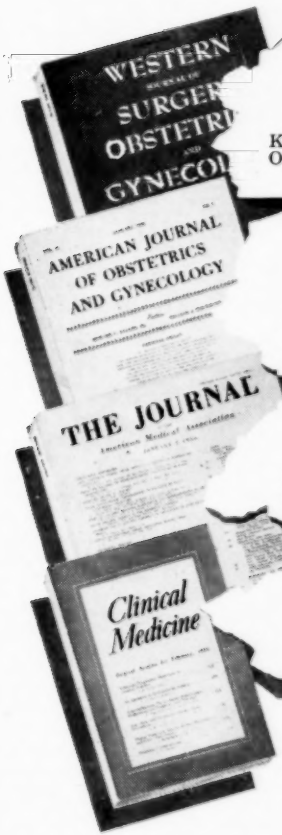
St. Boniface

St. Boniface Hospital

Sr. D. Clermont who was successively superintendent of nurses and director of nursing services of this hospital has been called to Fort Frances, Ont. She is now the Sister Superintendent of La Verendrye Hospital in that city.

TAMPAX

a clinically accepted method of menstrual hygiene



"Free from harm or irritation to the vaginal and cervical mucosa."

Karnaky, K. J.: Western Journal of Surgery, Obstetrics and Gynecology, Vol. 51, pp. 150-152.

"No evidence that the use of the tampon caused obstruction to menstrual flow."

Thornton, M. J.: American Journal of Obstetrics and Gynecology, Vol. 46, pp. 259-265.

"Does not impair standard anatomic virginity."

Dickinson, R. L.: The Journal of the American Medical Association, Vol. 128, pp. 490-494.

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Sackren, H. S.: Clinical Medicine, Vol. 46, pp. 327-329.

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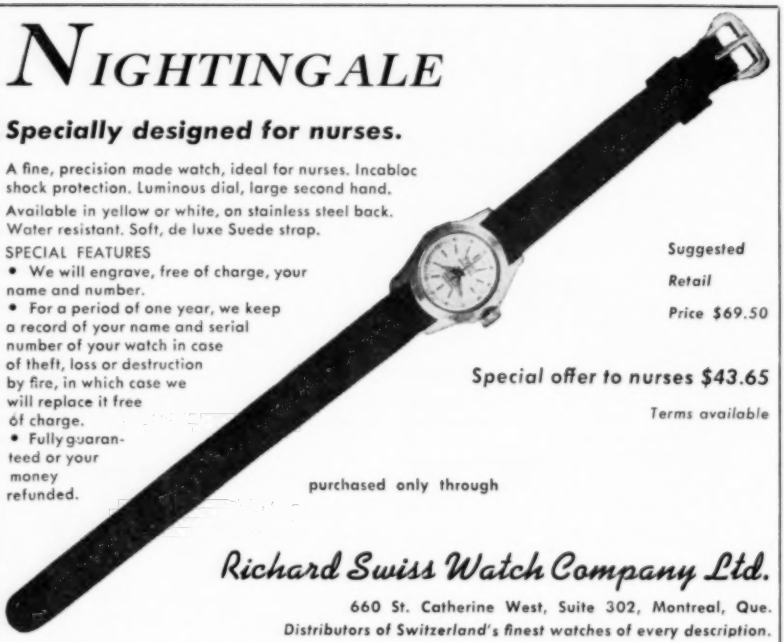

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WINNIPEG

General Hospital

One hundred and one new students, who now comprise the class of 1960 B were recently welcomed to the school of nursing. The girls and their parents had an opportunity to meet one another, and their teachers at a tea given in their honor. Before the group dispersed, Miss Margaret Cameron, director of nursing, formally introduced the teaching staff, some of whom were also new to the school. These were: E. Holland, Mrs. M. Klassen, Mrs. L. Walker, who are assistants in the nursing department; R. Niemark, science instructor; G. Morgan, instructor in nutrition; P. Edward and P. McBride, clinical instructors, Mrs. A. Price, recreational supervisor.

Again this year, Mr. W. A. Murphy, chairman of the hospital board, entertained the nursing faculty at a dinner, and as always "a good time was had by all." In turn, the faculty have also been entertaining in honor of staff members who have served for many years, and who now have entered other positions. Miss E. Timlick for many years secretary to the hospital administrator, was presented with an appropriate gift on the eve of her retirement from these duties. Now she is busy as assistant to Dr. Coppinger compiling data for the hospital archives. Miss Dorothy Hibbert who has given many years of service as Director of Nursing Services, was honored with a gift, and received congratulations on successfully completing studies which now give her a masters' degree in nursing administration. She will continue her studies for another year in the field of nursing service.

The alumnae association held its first meeting of the season in October. It was announced that P. Edward would take over as representative to *The Canadian Nurse* replacing O. Henkelman, who was married recently. The business discussion included recent publications of the association — one being the school of nursing history written by Miss Ethel Johns. Each copy is selling for two dollars and can be purchased through Miss J. Morgan.

At the close of the meeting, I. Cooper, L. Johnson and J. De Brincat gave an account, supplemented with colored slides of their trip to Rome and their attendance at the ICN this year. The student nurses have been busy sewing, knitting and mailing out invitations for their annual Year Book Tea. The class of '58 sponsored the tea with J. Malaher and E. Russell as conveners.

Congratulation are extended to Mrs. N. Lynch, A. Greene, N. Caswell, Mrs. M. Barwinsky, who have been promoted to head nurse positions recently, and to A. Aikman who was promoted from assistant director of nursing service to associate director of nursing service.

The Outpatient Department Staff was the first to move into the new wing. Pharmacy and X-ray will be next.

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NEW BRUNSWICK

MONCTON

Mr. D. Billings, civil defence coordinator for the eastern section of the province, discussed the planning that has been done for this area at a recent chapter meeting. M. Hollenbeck presided and Moncton Hospital residence was made available to members for the evening. A social hour followed.

Nurses' Hospital Aid

Mr. Don Billings, civil defence coordinator for the south eastern division of the province, addressed the members at a regular meeting on developments in civil defence for that area. Delegates who attended the Maritimes Hospital Auxiliaries convention in St. Andrews earlier this year presented their reports. A report concerning the operation of the canteen showed a very successful year.

NEWCASTLE

The annual chapter meeting followed the regular September one as members resumed activities for the fall and winter seasons. The following slate of officers was presented and accepted: Pres., Mrs. B. Norris; vice-president, Mrs. M. Grey, K. McLean; secretary, I. Loggie; treasurer, G. Schofield; Committee chairmen: Program, L. MacMillan, Sr. Skidd; legislation and by-laws, Sr. Sanford; public relations, D. Fraser; nursing education, E. MacDonald; nursing service, Sr. Hackett. Guest speaker on this occasion was Dr. M. Babineau from the provincial Department of Health.

ONTARIO

DISTRICT 5

TORONTO

General Hospital

E. Cureatz is doing private nursing in Miami, Florida. M. McArthur has been promoted to the rank of squadron leader with the R.C.A.F. and is now stationed in Ottawa following her return from Europe. E. Follett has joined the teaching staff of Western Hospital. R. Moir has joined the Public Health Department at Port Arthur. J. McMillan is with the City Health Department and D. Clough is doing public health work at Picton. Jessie F. Young has joined the teaching staff following several years of nursing in California. J. Glanville and A. Scott are nursing in Hawaii. P. McCleary has accepted a position with the health unit of the T. Eaton Company. P. Rae has joined the Department of Public Health in Toronto and L. Dickin is with the North York health agency following completion of post-

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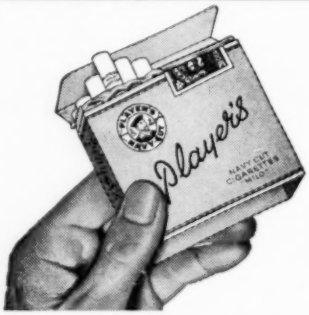

Player's Please

THE MILDEST
BEST-TASTING
CIGARETTE

graduate study at the University of Toronto. Mildred (Mann) Jeffrey has resigned from the social service department of Wellesley Hospital. She has been a part of many aspects of social work including a research project at the University of Toronto and glaucoma research in her home hospital.

Miss Jennie Ives has resigned her position as assistant superintendent of nursing. A member of the hospital staff for 15 years, she was a science instructor before joining the nursing school office staff. A purse and cheque were presented to her by members of the medical, nursing and clerical staff at a tea held in her honor earlier this year.

Jean MacKay has been appointed Director of Nursing Service. Prior to accepting this position, Miss MacKay had worked in Yellowknife, Women's College Hospital and in her home hospital as a clinical instructor. She obtained her degree in nursing at the University of Western Ontario in 1956.

F. Davies has replaced N. (Grunsell) Brown as head nurse on Ward 1. M. Alldread is presently working in Vancouver and she has been replaced by I. Hagen. R. A. Cross has also gone to Vancouver. A. Nemerosky and B. Morrison have joined the teaching staff as instructors in nursing arts while I. Krewenchuk is a science instructor. M. Drew and B. White have returned as clinical instructors following completion of their university studies.

QUEBEC

District 3

Sherbrooke

A joint meeting of the English and French chapters was held earlier in the fall in Norton Residence, Sherbrooke Hospital. Miss C. Aitkenhead presided. It was agreed by the group that amendment of the by-laws providing greater uniformity for both English and French versions should be considered. Miss Aitkenhead provided the highlight of the meeting with her illustrated description of her trip through Europe and attendance at the ICN congress.

Sherbrooke Hospital

Thirteen new graduates received their pins and diplomas at ceremonies held in St. Andrew's Presbyterian Church late in September. Professor James Gray of Bishop's University and Dr. J. L. Ross of the Hospital medical staff were guest speakers. The annual graduation dinner and dance was held at the Connaught Inn under the sponsorship of the alumnae association.

A. MacLeod visited the hospital during the summer and plans to do general staff nursing in Las Vegas, Nevada. C. Westover who is presently working in Boston, also visited. B. Littlejohn has joined the nursing office staff following her return from Colorado. Alumnae members are to receive a newsletter compiled by J. Keating to help them keep in touch with activities at their home school.

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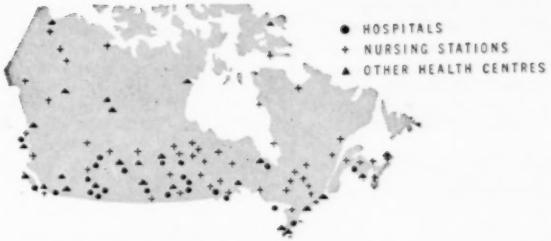

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(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

EXECUTIVE SECRETARY TREASURER

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District 11

Montreal

One of the projects of the Nursing Education Committee for this year is to provide a means whereby the schools of nursing could begin the preparation of instructors to teach the course in "Growth and Development" in the preliminary period as recommended in the interim curriculum as reported by the Curriculum Committee. Dr. S. M. Rabinovitch, director of the Department of Psychology, Montreal Children's Hospital and a member of the faculty of the Department of Psychology, McGill University, agreed to direct this assignment. The method selected is to have a two-hour discussion period with the group twice a month commencing in October and ending the first of April. This will mean approximately 24 hours. The group consists of 14 to 16 members, with each school limited to two participants — the nurse selected to teach the course and the instructor in the first nursing course or the director of the department of nursing education. Nurses with special preparation in this field will be at the meetings to assist Dr. Rabinovitch and to act as resource people for the discussion group. The Committee believes these sessions will be most worthwhile and should be of great assistance to nursing educators in the area.

The Nursing Education Committee also sponsored a Film Festival for graduate and student nurses during the month of October. The program included films relating to Nursing in the Community, Team Work, Medical-Surgical Nursing, Mental Health and Maternal and Child Health. These films created considerable interest for all nurses who were able to attend the showings.

As many of these films are difficult to obtain, it is the hope of the Committee that the means may be found so that these valuable films may be made available for nursing education in the future.

General Hospital

Three hundred and eleven nurses attended the dinner given in honor of the graduating class by the alumnae association early this summer. The dinner was held at the Ritz Carlton Hotel and Dr. Lloyd Stevenson, Dean of Medicine at McGill University, was the guest speaker. M. Middleton has retired from her position as charge nurse with the Sun Life Company of Canada. B. Zinck has joined the staff of Guy's Hospital, London, Eng. C. Legge has recently returned home after two years of nursing experience in London, England. A. Shea is now head nurse on 13th Floor East following completion of postgraduate studies at McGill University. C. Currier has been granted leave of absence to attend the University of British Columbia. F. MacKenzie and I. Rumsey are completing studies for their degrees in nursing at McGill University. E. Strike and M. Heron are also attending McGill University this year. A. D. Gillies has resigned as charge nurse of the case room. E. M. Gilbert has returned to the staff of the teaching department after completing studies for her degree in nursing at McMaster University. J. Anderson has accepted the position of director of nursing at the Victoria Public Hospital, Fredericton. M. Milligan has been appointed assistant to the supervisor of the Outpatient Department. J. Pennell has been appointed nurse in charge of the recovery room. M. Buzzell has recently returned to the teaching staff.

The alumnae association gratefully acknowledges a donation of $300 to the Norah Livingston Fund in memory of Mrs. Alice (Cashen) Gilmour, a member of the class of 1892. The gift was given jointly by Mr. and Mrs. A. W. McMaster, Mr. and Mrs. W. R. McMaster and Mr. and Mrs. H. L. Webster.

Miss Vera Brittain, prominent English novelist and biographer, was the guest speaker at the October meeting of the alumnae association.

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Director of Nurses for 155-bed, fully accredited, (new — 1954) hospital situated in the Columbia River valley. All graduate staff. Degree in nursing administration desirable but secondary to successful experience as nurse executive. Salary $425 to commence; reviewed annually. 28 days annual vacation; statutory holidays; sick leave. Private suite in residence, $20 monthly. Applicants must be eligible for B.C. registration. Apply, stating age, experience, references and including recent photograph, to the Administrator, Trail-Tadanac Hospital, Trail, B.C.

Hospital Superintendent for modern 28-bed hospital (Duties to commence immediately.) Supervisory ability necessary. Excellent living quarters. Apply stating references, age, experience & salary expected to Sec., Mrs. M. S. Leslie, The Executive Committee, Bingham Memorial Hospital, Matheson, Ontario.

Superintendent or Assistant Superintendent. An opening for one of the above positions will be available shortly for 40-bed Convalescent Hospital in metropolitan Toronto area. Apply stating references, age, experience & salary expected to Box #R, The Canadian Nurse Journal, 1522 Sherbrooke St. W., Montreal 25, Que.

Administrator for 30-bed Wood River Convalescent Center, now under construction. Write stating experience & qualifications to Miss Dorothy Alexander, Lincoln County Public Health Nurse, Court House, Shoshone, Idaho.

Operating Room Supervisor (Postgraduate course in O.R. technique required) for 140-bed hospital. Full maintenance. Travel arrangements. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Assistant Operating Room Supervisor for 800-bed hospital (5 Operating Room Theatres.) Position requires postgraduate course in operating room & experience. Apply to the Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Medical—Surgical Instructor. Classroom & clinical teaching. Classes approximately of 20 students. Apply Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Pediatric Head Nurse with postgraduate or equivalent experience. Operating Room Nurses & General Duty Nurses for 110-bed hospital in the Fraser Valley, 68 mi. from Vancouver with good bus service. Personnel practices in accordance with the R.N.A.B.C. policies. Accommodation in residence if desired. Further particulars available. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

Head Nurses & Registered General Duty Nurses for surgical, medical & obstetrical depts. Gross salary for nurses currently registered in Ont.: $235 per mo. — extra allowance made for Head Nurses. Good Personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift, 44-hr. wk. 1-day off 1-wk., 2 the next. 1½ day holiday allowed per mo., same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to $40 after 1-yr. service. Apply Superintendent, Lady Minto Hospital, Cochrane, Ont.

Assistant Head Nurses, Assistant Operating Room Nurse & Staff Nurses. Excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $225 per month. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

Registered Nurses for General Staff Duty & Operating Room in modern hospital opened February, 1956 & situated in the midst of one of Canada's most prosperous mining districts. Beginning salary:: $240 per mo., plus annual bonus plan, merit increase in 6-mo. to $250 per mo., subsequent increases to $270. Sick leave accumulative to 60-days. Free laundering of uniforms. Partial refund of transportation. Apply Director of Nursing, Memorial Hospital, Regent St. S., Sudbury, Ontario.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $320 with 4 annual increases to $360. Full maintenance $45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $300 per mo. starting salary. $15 per mo. increases at 6, 12, 24 & 36 mo. 40-hr. wk. Paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Nurses: Salary range: $315-$391; rapid advancement to Head Nurse, range: $351-$436. 200-bed modern hospital in "Heart of Feather River Recreation Area," near proposed Feather River Dam site. Liberal fringe benefits. 40-hr. wk. 12 holidays. 2-wk. vacation. 1-day sick leave per mo. accumulative to 60 days. Night & P.M. differential. Retirement plan. Group Health Ins. & maintenance available. Apply Director, Nursing Service, Butte County Hospital, Oroville, California.

Graduate Staff & Operating Room Nurses for 225-bed General Hospital, near New York City. Salary: $280, including benefits, $30 bonus for evening, $25 for night, extra for call duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, New York.

Staff Nurses for modern 650-bed Tuberculosis Hospital affiliated with Western Reserve University approved by joint commission on accreditation of hospitals. 40-hr., 5-day wk. Beginning salary: $286 with automatic increases. Advancement for eligible applicants. Full maintenance available at minimum rate, housing for 2 or more nurses. Meets approved minimum employment standards of the State Nurses' Association. Apply Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Staff & Surgical Nurses. Salary: $260, differential for evening & night plus 1 meal, OR $275. $100 for travel expenses. Resort area, beaches & college town. Please apply Director of Nursing, Grandview Hospital, Edinburg, Texas.

Registered Staff Nurses. Never a dull moment for the graduate nurses who decide they would like to join us at the University of Texas Medical Branch Hospitals. 40-hr. wk. in our air-conditioned hospitals leaving 128 hrs. to enjoy the beach & nearby resorts. Galveston boasts an average temperature in the low seventies which means that swimming, fishing, horseback riding & sailing can be enjoyed the yr. round. Positions available in the clinical area of your choice. Monthly salary begins at: $290 for rotating — $304, for extended evenings or nights. Uniforms laundered free. Liberal personnel policies & opportunities for advancement. Comfortable air-conditioned residences including maid service at moderate cost. Excellent opportunities for advanced study leading to both B.S. & M.S. degrees. Write for further information to Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas.

Registered General Duty Nurses (2) immediately for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $230 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alta.

Registered or Graduate Nurses (2) for 18-bed General Hospital, situated on the beautiful Arrow Lakes, B.C. Standard salaries, semi-annual increases. 40-hr. wk. Holidays. 'Living-in' accommodations available at low cost. Apply to the Administrator, Arrow Lakes Hospital, Nakusp, British Columbia.

Registered Nurses (1, for Operating Room; 1, for General Duty) for 34-bed, fully equipped, modern hospital located on main line of C.P.R., C.N.R. & No. 1 Highway. O.R. Salary: $240; R.N. Salary: $230. Full maintenance at $35 per mo. 44-hr. wk. Apply Matron, District Hospital, Virden, Manitoba.

Registered General Duty Nurses (4) for 105-bed Pembroke Cottage Hospital as replacements for ones who have been married. Pop. of town, 15,000. 8-mi. from Camp Petawawa, 2-hr. from Ottawa & 4-hr. from Montreal with excellent train & bus service. Active, interesting community social life in heart of the beautiful Ottawa Valley. Active ski club, curling club & skating, also the home of the famous Pembroke Lumber Kings Hockey Team. 2-theatres & a "drive-in". Nurses residence is available if desired, 2 blocks from the hospital. Gross salary: $210-$235 with increase at the end of 6-mo. & 1 yr. 3-wk. vacation, 7 statutory holidays. 14-day sick leave. No night duty. Blue Cross Medical/Surgical participation. Forward application to the Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Registered Nurse for fully modern 15-bed hospital. Regulation salary & benefits. Bonus of $180 after 1-yr. service. Apply Matron, Union Hospital, Maidstone, Saskatchewan.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $210 per mo., $5.00 increase every 6-mo. for 5 increases. Monthly bonus for permanent evening & night shifts. 44-hr. wk. Many attractive benefits. Board & accommodation available at minimum cost in new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for 105-bed accredited General Hospital. Salary: $330-$360 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Director of Nurses, Glenn General Hospital, Willows, California.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Nurses — eligible for registry — immediate openings for general duty & surgery. Starting salary: $275 per mo. 40-hr. wk. Maintenance furnished if desired. Hospital located 12 mi. south of Portland with educational & cultural advantages; near mountains & seashore. Apply to Director of Nurses, Oregon City Hospital, 515 Tenth St., Oregon City, Oregon.

Registered General Duty Nurses (100-bed.) Good bedside nursing required. 40-hr. wk. Rotating duties. Excellent personnel policies. You can arrange for R.I. State Registration. Apply Nurse Director, Jane Brown Memorial Hospital, Providence 3, Rhode Island.

Registered Nurses! Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment." Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, T.B. San (adults and children) and Operating Room. Salaries: $285-$315, days; $10 differential for evenings and nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E., Albuquerque, New Mexico. Phone 3-5611.

General Duty Graduate Nurses (2). Salary: $250. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

Graduate Nurses for 33-bed General Hospital 45 mi. from Sudbury. Salary: $265-$315. Half yearly increments. Blue Cross & laundry provided. Please apply Superintendent, General Hospital, Espanola, Ontario.

Graduate Nurses for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: $200 per mo. Annual increase $10 per mo. for 3 yrs. 2-wk. shift rotation bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

Graduate or Registered General Duty Nurses (2). Salary: $245 per mo. gross. 3-wk. vacation with pay after 1-yr. service. $5.00 per mo. raise after each 6-mo. service for 2-yrs. Fully modern nurses' residence in same building. Write or phone, Vernon Ross, Secretary, Kincaid Union Hospital, Kincaid, Saskatchewan.

Graduate General Duty Nurses for tuberculosis sanatorium. Starting salary: $240, increments every 6-mo., maximum: $260. No night or evening duty. 5-day, 40-hr. wk. 4-wk. vacation with pay after 1-yr. service. Time & one-half for all statutory holidays worked. Pension plan & other benefits. Apply Superintendent of Nurses, Prince Albert Sanatorium, Prince Albert, Saskatchewan.

Graduate Nurses (2) immediately for 11-bed hospital. Straight 8-hr. rotating shift. For further information please contact: Sister Superior, Hospital Notre Dame, Val Marie, Saskatchewan.

General Duty Nurses, $255. 40-hr. wk. 28-day vacation yearly plus 10 statutory holidays. Sick leave 1½ days monthly, accumulative after 6-mo. Room & full board $25 per mo. Fare from Vancouver advanced or refunded after 6-mo. service. Apply Matron, St. George's Hospital, Alert Bay, British Columbia.

General Duty Nurses. Salary: $240-$280, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses & Operating Room Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary $240-$273. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses (Immediately) to staff a new ward for General Hospital. Salary: $250. 40-hr. wk. 28-day vacation; 10 statutory holidays. Sick leave, full benefits. Accommodation in nurses' residence. Please apply Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn. Boating, fishing, swimming, golfing, curling & skiing. Initial salary: $270. Maintenance, $45. 44-hr. wk. 4-wk. vacation with pay. Comfortable, attractive nurses' residence. Rail fare advanced if necessary. References required. Apply Bulkley Valley District Hospital, Smithers, British Columbia.

General Duty Nurses. Starting salary: $248 per mo., $10 additional for 2 yr. continuous past experience. 4 annual increments of $10 per mo. to B.C. Reg'd. nurses. $20 per mo. for one or more years university training & $10 per mo. for hospital postgraduate clinical training of not less than 4 mo. 28 days annual vacation after 1 yr. service, 10 statutory holidays per yr. 1½ days sick leave per mo. cumulative. Room rent at nurses' residence $20 per mo. Promotions to senior positions from permanent staff. For details apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

General Duty Nurses for new 85-bed hospital. Good salary & generous personnel policies. Apply to the Director of Nursing, Portage Hospital Dist. # 18, Portage la Prairie, Manitoba.

General Duty Nurse: The Blanchard-Fraser Memorial Hospital (71-bed) located in Kentville, Nova Scotia, offers a General Duty Nurse ideal working conditions. 1 mo. annual vacation, excellent personnel policies plus modern living quarters with full maintenance in new nurses residence. For further information apply to Superintendent of Nurses.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for all departments. New addition to hospital recently opened. Good personnel policies. Apply to Director of Nursing, General Hospital, Belleville, Ont.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted for its great skiing on the Blue Mountains, along with ice skating & curling on artificial ice. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $225 per mo. with annual increments. Good personnel policy with sick leave benefits, holidays & paid vacation. Residence accommodation available. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses, O.R. Nurse & Certified Nursing Assistant for 70-bed General Hospital. Apply Acting Director of Nursing, Ross Memorial Hospital, Lindsay, Ontario.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for Ear, Eye, Nose & Throat Operating Room. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ontario.

General Duty Nurses & Certified Nursing Assistants for 25-bed hospital in northern Ont. Starting salary: $240 per mo. & $170 per mo. Room & board $28.50 per mo. 5½-day wk. 8-hr. duty. Annual vacation. 1-day sick leave per mo. after 6-mo. Apply Superintendent, Mrs. G. Gordon, District Memorial Hospital, Nipigon, Ontario.

General Duty Nurses for all departments. Gross salary: $235 per mo. if registered in Ontario, $215 per mo., until registration has been established. $20 per mo. bonus for evening & $10, night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 12 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

Matron (Registered Nurse) preferably with experience in the management of a small hospital. Salary: $300-$350 per mo. depending on experience. For more information apply to: John Hiscock, Baldur Medical Nursing Unit, Baldur, Manitoba.

Nurses — General Duty: $330 up plus $20 p.m. shifts. **Surgery:** $430 plus $10 call-out. 40-hr. wk. Social security; paid vacation; 10-day sick leave. Hospital group insurance. 5-yr. salary & benefit increment. Apply Director of Nurses, Corning Memorial Hospital, Corning, California.

General Duty Nurses (English speaking) for 466-bed hospital. Salary: California registered, $315 — Canadian registered, $285. Differential: $22.50 for 3-11 & 11-7 shifts. Nurses' residence available. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, California.

General Duty Nurses, Operating Room Nurses for 64-bed acute treatment, fully accredited hospital in northern California. Excellent living conditions. For full details at once on salaries, working conditions, paid vacations, paid holidays, paid sick leave & other benefits apply to Director of Nursing Services, Woodland Clinic Hospital, Woodland, California.

Operating Room & General Duty Nurses for new 63-bed hospital, 35-mi. from Vancouver. Hospital expected to open about January, 1958. Apply Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Operating Room Nurse (Immediately — 2 or 3 yrs. experience in O.R. technique preferable). Salary: $250 basic, plus $10 'on-call' allowance, plus credit for P.G. & 2-yr. satisfactory experience. Board & room available at $49.50 per mo. Apply stating age, qualifications & experience to Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

Operating Room Nurse for modern Operating Room suite. Experience preferred. Please apply stating salary expected to Superintendent, Lady Minto Hospital, Cochrane, Ont.

Laboratory Technicians (For U.S.A.) experienced in all clinical procedures of General Hospital Laboratory. Interesting position. Advancement. Apply Morristown Memorial Hospital, Morristown, New Jersey.

Public Health Nurses for generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurse (Immediately) experienced in tubercular work. Must be able to drive. Bilingual. Excellent salary. Apply to: 1667 Lajoie Ave., Outremont, Quebec, or call Crescent 4-1638.

Registered General Duty Nurses. Living in accommodation. Personnel policies equal the best. **Laboratory Technician (immediately).** Registered or equal qualifications. Well organized dept. For full particulars apply Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

Operating Room Supervisor for large Sanatorium. Experience in Chest Surgery desirable. Salary according to qualifications. Good personnel policies. Apply Director of Nursing Service, The Beck Memorial Sanatorium, London, Ontario.

Clinical Instructor, Assistant Night Supervisor, General Staff Nurses for new 230-bed hospital with school of nursing. Good personnel policies. Apply Director of Nursing, The Children's Hospital of Winnipeg, Winnipeg, Manitoba.

Registered General Duty Nurses (2). Salary: $220 per mo. plus perquisites & laundry. $5.00 increase every 6-mo. employment. Apply to the Matron, Municipal Hospital, Rimbey, Alta.

Registered General Duty Nurses (Immediately). Salary: $230 per mo. Excellent personnel policies. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Attention General Duty & O.R. Nurses. 400-bed County Hospital located 2-hr. drive from San Francisco, ocean beaches or mountain resorts. **Surgery:** $349-$419 rotating call. **General Duty:** $304-$365 plus shift & service differential. 40-hr., 5-day wk. 3-wk. paid vacation, 11 paid holidays. Paid sick leave, retirement plan. Accommodation in nurses' home. Laundry & meals at reasonable rates. Must be eligible for California registration. Apply Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

TO MEET A RAPIDLY EXPANDING HOSPITAL SITUATION: THE WINNIPEG GENERAL HOSPITAL IS RECRUITING

1. **A CLINICAL COORDINATOR:**

   To coordinate & further develop the orientation program for the graduate nurses. To administer & further develop the clinical instruction program for the student nurses.

   Qualifications:

   a. Minimum, a B.A., or B.Sc. degree in nursing education.
   b. Desirable but not essential, a Master's degree or equivalent education & experience.

2. **AN ASSOCIATE DIRECTOR OF NURSING EDUCATION:**

   To supervise & assist in the organization & development of the educational program for the school of nursing.

   Qualifications:

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   b. Desirable but not essential, a Master's degree or equivalent education & experience.

3. **AN OPERATING ROOM SUPERVISOR.**
4. **CLINICAL INSTRUCTORS IN MEDICINE & SURGERY.**
5. **GENERAL DUTY NURSES FOR ALL SERVICES.**

Please send applications direct to: **THE DIRECTOR OF NURSING, THE WINNIPEG GENERAL HOSPITAL, WINNIPEG 3, MANITOBA.**

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Registered Nurses for new modern 16-bed hospital.

Salary: $260 per mo. less $35 for full maintenance.

Will pay train or bus fare one way.

1-mo. vacation with pay after 1-yr. service.

Apply to:

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Registered & Licensed Practical Nurses (Immediately) for 36-bed General Hospital. Top salaries paid with other fringe benefits. Please write for further particulars to: Superintendent of Nurses, District Hospital, Aitona, Manitoba.

Registered Nurses. Salary: $295, with periodic increases. Excellent personnel policies. For further information please contact Superintendent, City Hospital, Red Wing, Minnesota.

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Positions available for qualified Public Health Nurses in various centers in British Columbia.
Salary: $290 rising to $345 per mo. Car provided. An opportunity for interesting & challenging professional service in this beautiful & fast-developing province. Competition No.: 57:591.

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THE DIRECTOR, PUBLIC HEALTH NURSING, DEPT. OF HEALTH, VICTORIA, B.C. OR THE CHAIRMAN, B.C. CIVIL SERVICE COMMISSION, 544 MICHIGAN ST., VICTORIA, B.C.

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REGULAR AND VACATION RELIEF POSITIONS IN PEDIATRICS, OBSTETRICS, MEDICINE AND SURGERY

1500 bed teaching hospital, heart of British Columbia's medical centre

ATTRACTIVE PERSONNEL POLICIES

Salary $249 — $289 per month. 5 day, 40 hour week

(Eligibility for registration in B.C. necessary)

PLEASE APPLY TO PERSONNEL DEPARTMENT, VANCOUVER GENERAL HOSPITAL, VANCOUVER, B.C.

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IN

MEDICAL & SURGICAL NURSING

PEDIATRIC NURSING

Recent university postgraduate course and teaching experience preferred. This is a modern 300-bed hospital, located in a progressive, industrial city of 45,000 population. The school for nurses is well-equipped, and has a total student enrolment of 72.

Annual starting salary: $3,419 with increments to $3,887.

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REGISTERED NURSES

Salary range $325-$360 per month; differential on p.m. shift $1.50, nights $1.00.

Openings in Obstetrical and Medical-Surgical services.

Apply to Personnel Department,

WOMAN'S HOSPITAL
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OPERATING ROOM SUPERVISOR

REQUIRED IMMEDIATELY

for new 300-bed General Hospital, in operation since February, 1956.

For further information please apply:

DIRECTOR OF NURSING,
MEMORIAL HOSPITAL,
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REGISTERED NURSES
$2,700-$3,540
ACCORDING TO QUALIFICATIONS

CERTIFIED NURSING ASSISTANTS
$2,130-$2,310

SUNNYBROOK HOSPITAL 5-day week **WESTMINSTER HOSPITAL**
TORONTO **LONDON**

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Offices, should be forwarded to the

CIVIL SERVICE COMMISSION, 25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO

APPLICATIONS WILL BE ACCEPTED BY THE

SECRETARY OF THE BOARD OF GOVERNORS,

KINGSTON GENERAL HOSPITAL, KINGSTON, ONTARIO

for the position of

DIRECTOR OF NURSING

GRADUATE NURSES — SUBURBAN TORONTO

Are invited to enquire re: employment opportunities in a well-staffed new 125-bed hospital in suburban west Toronto. General duty salary range: $225 to $275 per mo. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST. WESTON, TORONTO 15, ONTARIO. CHerry 4-5551.

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SENIOR AND STAFF POSITIONS IN HEALTH UNITS

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New Salary Schedule in effect since 1st April, 1957.

Application forms and details from:

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OF PUBLIC HEALTH,
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EDMONTON, ALBERTA

The Toronto General Hospital

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Registered Nurses

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For Medical, Surgical and Obstetrical Services.

Excellent opportunities as our facilities are expanding.

Good Personnel Policies, including Pension Plan.

Apply to:

Director of Nursing
Toronto General Hospital,
Toronto 2, Ontario.

TORONTO HOSPITAL

(for Tuberculosis)

WESTON (TORONTO 15)

ONTARIO

Applications are invited from graduate nurses for general duty staff appointments in metropolitan Toronto. Opportunities for advancement. Pension plan. Accumulative sick leave. Residence for nurses available. Also postgraduate course.

For further information apply to:

Director of Nursing,
Toronto Hospital for T.B.
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Toronto

Modern 400-bed Hospital

requires

REGISTERED NURSES

and

Certified Nursing Assistants

Good Salaries and Personnel Policies

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SCIENCE INSTRUCTOR

for

BRANDON GENERAL HOSPITAL

SCHOOL OF NURSING, BRANDON, MANITOBA

60-STUDENTS, 2 CLASSES PER YR. 148-BED HOSPITAL

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DIRECTOR OF NURSING

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NEW 85-BED GENERAL HOSPITAL

School of Nursing planned to open September

Salary schedule commensurate with experience

Enquiries are invited from qualified persons

Apply: THE PORTAGE HOSPITAL DISTRICT #18, PORTAGE LA PRAIRIE, MANITOBA.

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Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $295 per mo. 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

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REGISTERED NURSES

(General Duty with opportunity for advancement)

New modern 112-bed General Hospital in dynamic college city in beautiful San Joaquin Valley only 2 hours from Los Angeles

Salary: $325 to begin. Differential for evening & nights.

5-day, 40-hr. wk. Progressive personnel policies.

Transportation costs to California will be reimbursed after 1-yr. service.

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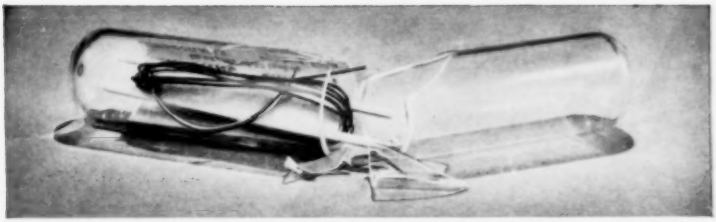

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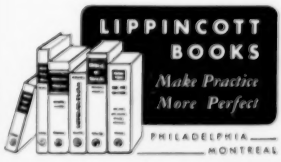
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